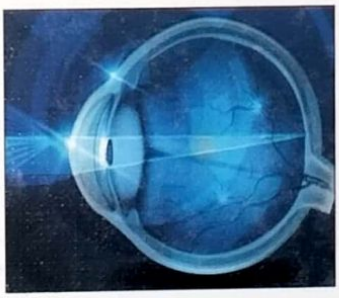
(Joyia Series)

SECRETS OF OSPE/OSCE

NRE II, UHS FINAL YEAR MBBS, 4TH YEAR MBBS & IMM EXAM



- Medicine
- Pediatrics
- Surgery
- Orthopedics
- ENT
- Ophthalmology
- Obstetrics
- Gynecology

Authors

Dr M Naeem Akhtar Joyia
Dr M Nadeem Akhtar Joyia
Dr Romana Naeem Joyia
Dr Sumera Akhtar Joyia

7th Edition

JOYIA Publishers

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QUOTES

- If ALLAH wants to do good to somebody, He afflicts him with trials. (Prophet Muhammad PBUH).
- The greatest Jihad is to battle your own soul, to fight the evil within yourself. (Prophet Muhammad PBUH)
- The best among you is the one who doesn't harm others with his tongue and hands. (Prophet Muhammad PBUH)
- Expect the best, prepare for the worst. (Muhammad Ali Jinnah)
- I don't believe in taking the right decision, I take a decision and make it right. (Muhammad Ali Jinnah)
- Failure is a Word, Unknown to me! (Muhammad Ali Jinnah)
- The Ultimate aim of the ego is not to see something, but to be something. (Allama Muhammad Iqbal)
- Listen to your elder's advice, not because they are always right but because they have more experiences of being wrong.
- You educate a man; you educate a man. You educate a woman; you educate a generation. (Brigham Young)
- Don't wait. The time will never be just right. (Napoleon Hill)
- He who is not courageous enough to take risks will accomplish nothing in life. I hated every minute of training, but I said, 'Don't quit. Suffer now and live the rest of your life as a champion. (Muhammad Ali Boxer)
- People have become educated, but have not yet become human. (Abdul Sattar Edhi)
- Compromise for your dream, but never compromise on your dream. (Imran Khan)
- Un Mundo Mejor is Possible….!!! (Fidel Castro)
- A Revolution is not a bed of Roses. A Revolution is a Struggle between the Future and The Past……!!! (Fidel Castro)
- The Only thing that can change your Destiny is Dua.
- Never regard study as a duty, but as the enviable opportunity to learn. (Albert Einstein)
- Live as if you were to die tomorrow. Learn as if you were to live forever.

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Unit 1

SECRETS OF DERMATOLOGY

Question 1

a. What is your diagnosis?
b. Write 5 causes?
c. What will be the treatment?

Answer:

a. Erythema Nodosum
b. i. Medications (sulfa related drugs, Birth control pills, Estrogen)
ii. Cat scratch disease
iii. Fungal Disease
iv. Sarcoidosis
v. Infectious Mononucleosis
vi. IBD (Crohn's disease & Ulcerative Colitis)
c. Treat underlying condition (treat associated disease)

Question 2

a. What is your diagnosis?
b. Write causing agent?
c. Write treatment?

Answer:

a. Acne Vulgaris
b. Propionibacterium acnes
c. In topical agents; benzoyl peroxide, antibiotics, retinoids, etc. are the mainstay of treatment. These can be given in combinations. While systemic therapy includes oral antibiotics, hormonal therapy and isotretinoin. It has to be selected depending upon the need of the patients.

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Question 3

a. What is the diagnosis?
b. Write 2 causing agents?
c. Write the treatment?

Answers:

a. Impetigo
b. i. Staphylococcal aureus
   ii. Streptococcal Pyogenes
c. Prevention: Hand washing, avoid people who are infected and cleaning injuries. Treated with topical fusidic acid and antibiotic Cephalexin.

Question 4

a. What is your diagnosis?
b. Write the causing agents?
c. Write Investigation?
d. Write 3 differential diagnoses?
e. Write treatment?

Answer:

a. Tinea Capitis
b. Microsporum Spp, Trichophyton Spp
c. Examination of the affected area with a Wood's light can help identify tinea capitis. Skin biopsy showing characteristic histopathological features of tinea capitis.
d. Seborrhic dermatitis, Psoriasis, Alopecia areata
e. Antifungal shampoo: Selenium sulfide 5-10 ml on wet scalp, 2 applications each week for 2 weeks will provide control.

Question 5

a. Write the diagnosis?
b. Write Investigations to confirm the diagnosis?
c. What will be the treatment options?

Answer:

a. Basal Cell Carcinoma
b. Skin biopsy is preferred for histopathological analyses. Most common method is shane biopsy under local anesthesia.
c. i. Standard Surgical Excision ii. Mohs Surgery iii. Cryosurgery iv. Electrode Siccation and Curettage v. Chemotherapy vi. Immuno therapy vii. Radiation viii. Photodynamic therapy

Question 6

a. What is diagnosis?
b. Name clinical subtypes.
c. Write common nail changes?
d. Write the treatment?

Answer:

a. Psoriasis
b. Pustular Psoriasis, Guttate Psoriasis, Psoriatic Erythroderma, Chronic Plaque Psoriasis
c. Nail thickening, Pitting, Splinter haemorrhages, Onycholysis, Subungual Hyperkeratosis
d. Topical Steroids, emollients, PUVA, UVB, Methotreaxte, Azathioprine, Cyclosporine, etc.

Question 7

a. What is diagnosis?
b. Which is the nerve supplying the area and Mention its branches?
c. Name the etiological agent causing this Disease?
d. Mention the name of the other disease Which can be caused by this organism?
e. Write the treatment?

Answer:

a. Herpes Zoster
b. Trigeminal Nerve, Ophthalmic and Maxillary divisions
c. Varicella Zoster
d. Chicken Pox
e. Narcotic analgesics and NSAIDS. Carbamazepine, tricyclic antidepressents, Pregabalin, Acyclovir.

Question No. 8

a. What is your diagnosis?
b. Write Name of causing agent?
c. Write name of antiviral drug used for treatment?

Answer:

a. Herpes Zoster (Shingle)
b. Varicella Zoster
c. Acyclovir

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Question No. 9

A 40 yr old man complains of widespread pruritis for the past 2 weeks. The itching is particularly bad at night. O/e he has noted to have a number of linear erythematous lesions in between his fingers.

a. What is your diagnosis?
b. Write name of causing agent?
c. Write topical treatment?

Answer:

a. Scabies
b. Sarcoptes Scabiei
c. Permethrin is the most effective treatment of choice.

Question No. 10

a. What is your diagnosis?
b. What is causing agent?
c. Name 2 drugs efficient for treatment?

Answer:

a. Herpes simplex (Herpes Labiales)
b. HSV-1
c. Acyclovir , Valacyclovir

Question No. 11

A 20 yr old Negroid man from Makkran coast stabbed on the upper arm, he received emergency treatment and his wound healed. He developed a raised hypertrophic scar with boundaries beyond the original wound and it did not regress.
What is your diagnosis?

Answer:

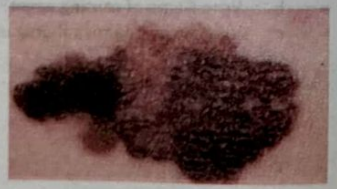
Keloid

Question No. 12

a. What is your diagnosis?
b. How will you confirm your diagnosis?

Answer:

a. Melanoma
b. Skin Biopsy



Question No. 13

a. Write diagnosis?
b. Where it can metastases?
c. Write treatment?

Answer:

a. Squamous cell carcinoma
b. It metastases to lymph nodes and Various parts of body
c. i. Treatment may include surgical procedures followed by radiation therapy or chemotherapy.
ii. Targeted therapy medications may also be used to destroy the tumor cells.

Question No. 14

a. What is your diagnosis?
b. Name 3 medications for treatment.

Answer:

a. Chicken Pox
b. i. Acyclovir
ii. Valacyclovir
iii. Famcyclovir

Question No. 15

a. What is your diagnosis?
b. How will you Confirm diagnosis?
c. Write treatment?

Answer:

a. Pemphigus Vulgaris
b. Pemphigus Vulgaris is confirmed By direct immunoflourescence Staining of the skin biopsy sections to reveal antibodies.
c. i. An anti-inflammatory drug called dapsone
ii. Corticosteroids
iii. Medicine containing gold
iv. Medicine that suppress the immune system (Azathioprine, Methotrexate, cyclosporine, cyclophosphamide, Mycophenolate, etc)

SECRETS OF PMDC III

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Question No. 16

a. Identify rash?
b. In which disease this rash is present?
c. Name 2 tests to diagnose the disease?

Answer:

a. Malar rash/ Butterfly rash
b. SLE
c. ANA, Anti dsDNA

Question No. 17

a. What is your diagnosis?
b. Write topical treatment?

Answer:

a. Lichen Planus
b. Topical steroids

Question No. 18

What is your diagnosis?

Answer:

Toxic Epidermal Necrosis

Question No. 19

a. What is your diagnosis?
b. Write treatment?

Answer:

a. Athlete foot
b. Topical
   i. Clotrimazole
   ii. Miconazole
   iii. Terbinafine
   iv. Tolnaftate

Question No. 20

a. What is your diagnosis?
b. Write treatment?

Answer:

a. Ring worm infection (Tinea Corporis)
b. Antifungal cream
   i. Miconazole
   ii. Clotrimazole

Question No. 21

a. What is your diagnosis?
b. What is treatment?

Answer:

a. Eczema herpeticum
b. Treatment oral acyclovir for 10 days , antibiotics like cephalexin

Question No. 22

Answer:

Erythema Toxicum naonaturum

Question No. 23

Answer:

Herpes Zoster (Shingles)

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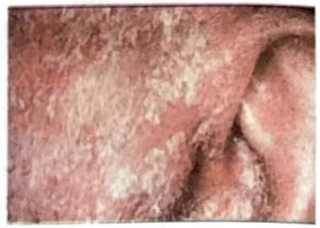
Question No. 24

Answer:
Psoriasis

Question No. 25

Answer:
Seborrheic dermatitis (dandruff) due to M.furfu



Question No. 26

Answer:
Tinea Corporis (Ringworm)

Question No. 27

Answer:
Tinea Versicolor

Question No. 28

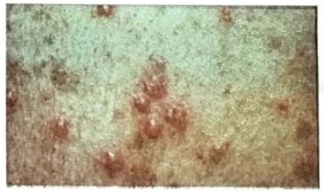
Answer:
Melasma (Pregnancy mask)

Question No. 29

Answer:
Toxic Shock Syndrome

Question No. 30

Answer:
Chicken Pox (Varicella)



Question No. 31

Answer:
Nail Pitting (Onchomychosis)

Question No. 32

Answer:
Pemphigus Vulgaris

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Question No. 33

Answer:
Bullous eruption of varying size with Surrounding erythema

Question No. 34

Answer:
Erythema Nodosum

Question No. 35

Answer:
Herpes Zoster

Question No. 36

Answer:
Malar Rash/ Butterfly Rash

Unit 2 SECRETS OF OPHTHALMOLOGY

Question 1

a. Identify what is it?
b. What is your diagnosis?
c. Write 3 investigations?
d. How will you treat?

Answer:

a. KF rings
b. Wilson disease or Hepatolenticular degeneration
c. i. serum copper and ceruloplasmin level
   ii. 24 hour urinary cu levels
   iii. Liver biopsy and histology
   iv. MRI Brain
d. Penicillamine, zinc phosphate, Trientene, SodiumTetrathiomolibdate

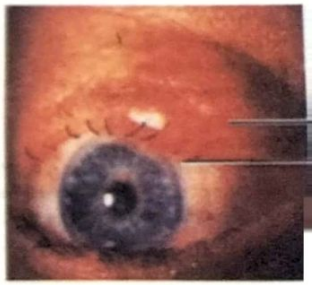
Question 2

a. What is your diagnosis?
b. Name organism involved?
c. Write treatment?

Answer:

a. Stye (Hordeolum)
b. Staphylococci infection
c. i. hot fomentation applied frequently in the early stage is useful
   ii. Evacuation of the pus by pulling the involved lash or incising the abscess is advised

d. Treatment:
   i. Antibiotic eye-drops and ointment are applied to control and prevent infection
   ii. Systemic broad spectrum antibiotics may be useful
   iii. Analgesics and anti-inflammatory drugs control pain and inflammation



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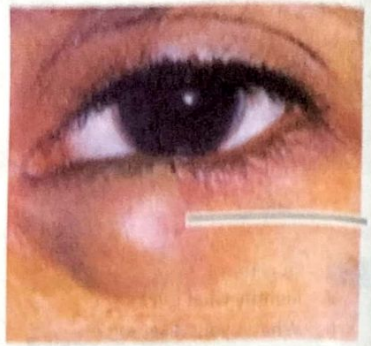
Question 3

a. What is your diagnosis?
b. Write etiology?
c. Write treatment?
d. Write differential diagnosis?



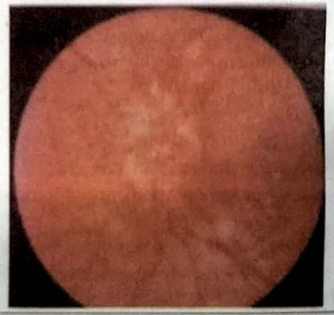
Answer:

a. Chalazion (Tarsal or Meibomian Cyst)
b. It is probably due to chronic irritation caused by an organism of low virulence. The glandular tissue is replaced by granulation tissue containing giant cells predominantly. It is more common in adults than in children
c. i. Small soft recent chalazion may undergo self resolution and disappear spontaneously but it can be helped by conservative treatment in the form of:
- Expression
- Hot fomentation
- Topical steroid: antibiotic combination drops
- Anti-inflammatory drops

ii. The large and persistent chalazion require the following treatment:
i. Medical: Corticosteroid injection
ii. Surgical
d. i. Sebaceous gland adenoma ii. Sebaceous gland carcinoma iii. Fungal infection iv. Sarcoid granuloma v. Dermal tuberculosis vi. Foreign body granuloma

Question 4

a. What is your diagnosis?
b. Write three causes?
c. Write treatment options.



Answer:

a. Papilledema
b. Raised intracranial pressure glauoma, optic neuritis
c. Treat the cause. Azetazolamide, Furosemide, steroids, avoidance of medications that raise ICP

Question 5

a. Identify condition?
b. Write causes?
c. Write name of disease?
d. Other eye signs?
e. Write treatment?

Answer:

a. Exophthalmos
b. The exact cause is obscure as it may be present in hyperthyroidism, hypothyroidism and elithyroid states. It may be associated with:
i. Generalised disturbance of the endocrine system
ii. Increased secretion of thyrotropic hormone (TTH) from the anterior lobe of pituitary gland in response to low thyroxin level
iii. Increased secretion of exopthalmos producing substance (EPS) and long acting thyroid stimulators (LATS)
c. Thyrotoxicosis
d. Ocular signs:
i. Bilateral exopthalmos with associated exposure keratitis
ii. Dalrymple's sign: there is peculiar stare due to retraction of the upper lid
iii. Von Graefe's sign: upper lid lags on downward movements of the eyeball
iv. Stellwag's sign: there is infrequent and incomplete blinking
v. Mobius's sign: there is weakness of convergence
vi. Jellinek's sign: there is increased pigmentation of lids
vii. Joffroy's sign: there is poor forehead wrinking on looking up
e. 1. Systemic iodide and antithyroid drugs are given in mild type
2. Systemic corticosteroids help to reduce the edema and infiltration
3. Exposed cornea is protected by lubricants and lateral tarsorrhaphy
4. Orbital decompression is indicated in rapidly progressing proptosis with optic nerve involvement

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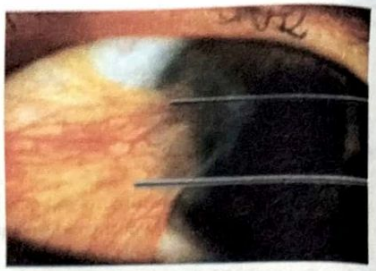
Question 6

This young lady labourer by profession presented with a growth over the nasal side of the left eye now complaining deterioration of the vision. Carefully read the scenario, observe the picture and answer the following questions:

a. What is the diagnosis?
b. What is the treatment?
c. How can you prevent this condition?



Answer:

a. Ptergium
b. Nonsurgical:
i. Tears substitute to control the dryness of cornea
ii. Topical steroids for inflammation
iii. Sunglasses to reduce ultraviolet light exposure

Surgical: Treatment of ptergium is surgical excision for cosmetic reasons, or when the ptergium progresses towards the visual axis.

c. Prevention of recurrence: Recurrence of ptergium after surgical excision is the main problem (30% to 50%). It can be reduced by one of the following procedures:

1. Conjunctival autograft or amniotic membrane transplantation: currently the most widely used technique involves excision of the ptergium and covering of the defect (bare area of sclera) with either a conjunctival autograft or amniotic membrane.
2. Mitomycin C: may be used at the time of surgery or after surgery in the form of topical drops.
3. Radiation: beta rays may be applied to the limbus in a dose of 2500 rad during the 1st week, after surgery.
4. Argon laser: is used to destroy the regrowth of new vessels at limbus

Question 7

a. What is your diagnosis?
b. Write types?

Answer:

a. Cicatricial Ectropion
b. i. Spastic Ectropion
ii. Mechanical Ectropion
iii. Cicatricial Ectropion
iv. Senile Ectropion
v. Paralytic Ectropion

Question No. 8

This two year old boy presents with misalignment of the right eye and inability to focus from that eye. By looking at the picture please answer the following questions?

a. What is the clinical
Sign seen in picture?
b. What is your diagnosis?
c. Write treatment?
d. Write 2 differential diagnosis?

Answer:

a. Leucocoria (White reflex)
b. Retinoblastoma
c. Depends upon the tumor size
Location and stage of growth, the treatment options are:

1. Tumour destructive therapy: is indicated when tumor involves less than half of the retina and optic nerve is not involved.

i. Chemotherapy ii. Photocoagulation
ii. Cryotherapy iv. Brachytherapy
v.external beam radiotherapy vi. Laser thermotherapy

2. Enucleation: is indicated when:
i. tumour involves more than half of the retina
ii. optic nerve is involved
iii. Glaucoma is present
iv. Laser thermotherapy

d. D/D
i. Congenital cataract
ii. Pseudoglioma

Question No. 9

a. What is diagnosis?
b. Write stages of underlying disease?
c. Write its management steps?

Answer:

a. Diabetic retinopathy
b. i. Background retinopathy
ii. Preproliferative
iii. Proliferative
iv. Maculopathy
c. Strict glycemic control
d. Laser photocoagulation

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Question No. 10

a. Write the sign name?
b. Write name of disease?
c. Name the diagnostic test.
d. What are treatment options?

Answer:

a. Bilateral Ptosis
b. Myasthenia gravis
c. Edrophonium (Tensilon) test
d. Pyridostigmine, Corticosteroids, Immunosuppressive therapy, Thymectomy

Question No. 11

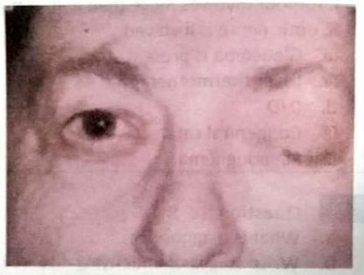
1. What is your diagnosis?
2. Write causes?

Answer:

1. Optic atrophy
2. Multiple sclerosis
3. Methanol poisoning
4. Neuromyelitis optica
5. Hereditary optic atrophy

Question No. 12

a. What is the lesion?
b. Why is eyelid drooping?
c. Name causes of this lesion.



Answer:

a. Third nerve palsy
b. Levator palpebrae superiors is supplied by occulomotor nerve
c. Diabetes, vasculitis, SLE, Rheumotoid arthritis, Aneurysm of posterior communicating artery

Question No. 13

a. What is diagnosis?
b. Write its stages?
c. Write emergency treatment?

Answer:

a. Hypertensive retinopathy. AV nipping
b. Grade 1 (mild retinopathy): arteriolar narrowing (generalized and focal), AV nicking and/or arteriolar wall opacity
Grade 2 (moderate retinopathy): hemorrhage, microaneurysm, cotton wool spot, and/or hard exudates
Grade 3 (malignant retinopathy): moderate retinopathy plus disc swelling
c. IV labetalol or IV nitroprusside

Question No. 14

a. Describe the abnormality?
b. Write diagnosis?
c. Write diagnostic test?
d. What are treatment options?

Answer:

a. Bilateral ptosis and lack of facial expression
b. Myasthenia gravis
c. Edrophonium(tensilon) test
d. i. pyridostigmine
ii. Corticosteroids
iii. Immunosuppressive therapy
iv. Thymectomy

Question No. 15

a. What is the abnormality shown?
b. Write causes of this condition?

Answer:

a. Complete ptosis of right eye
b. 3rd nerve palsy, myasthenia gravis, Horner's syndrome

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Question No. 16

a. What is your diagnosis?
b. Write cardiovascular complications of this disease?

Answer:

a. Grave's disease
b. CCF, atrial fibrillation, hypertension

Question No. 17

a. What abnormality seen in this patient?
b. What is the diagnosis?

Answer:

a. Exopthalmos
b. Grave's eye disease in a patient with thyrotoxicosis

Question No. 18

a. What is your diagnosis?
b. Write complications?
c. Write differential diagnosis?
d. Write treatment?

Answer:

a. Acute dacrryo-adenitis- both eyes
b. i.Suppuration leads to abscess and fistula formation
ii.There may be cystic degeneration and atrophy of the gland resulting in dry eye
c. It should be differentiated from lid abscess, stye, suppurative chalazion, acute purulent conjunctivitis, orbital celulitis and osteomyelitis of frontal bone
d. i. Hot compresses are applied several times a day
ii. Systemic broad-spectrum antibiotics are given in full doses
iii. Incision and drainage is done in cases of abscess formation

Question No. 19

a. What is your diagnosis?
b. Write classification of ptosis?

Answer:

a. Congenital ptosis
b. Acquired ptosis

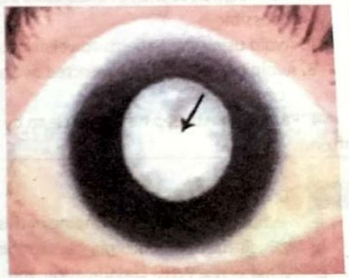
1. Unilateral Ptosis
   i. Partial
   ii. Complete
2. Bilateral ptosis
   i. Partial
   ii. Complete

Question No. 20

a. What is your diagnosis?
b. Write risk factors for this?
c. Write morphological classification?

Answer:

a. Mature Cataract (Senile)
b. i. Increasing age
   ii. Diabetes
   iii. Atopic dermatitis
   iv. Myotonic dystrophy
   v. Trauma
c. 1. Senile cortical Cataract (Soft Cataract)
      i. Cuneiform cataract
      ii. Cupuliform cataract
   2. Senile nuclear Cataract (Hard cataract)



Question No. 21

a. What is your diagnosis?
b. Write types?
c. What is treatment of each?

Answer:

a. Entropion
b. i. spastic entropion
ii.cicatricial entropion
c. Spastic entropion: The basic cause of blepharospasm is treated.
Cicatricial entropion: It is treated by operative procedures

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Question No. 22

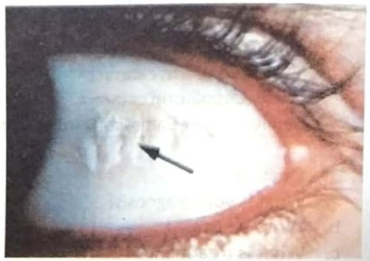
a. What is your diagnosis?
b. Write signs of this disease?
c. Write etiology?
d. Write prophylaxis?

Answer:

a. Acute mucopurulent conjunctivitis
b. i. Conjunctival congestion is always present. The conjunctiva is fiery red (pink eye or red eye)
ii. Chemosis and subconjunctival haemorrhage may be present
c. It is caused by several organisms such as Staphylococcus, Streptococcus, Pneumococcus, Haemophilus aegyptius, adenovirus etc. It is often associated with measles and scarlet fever.
d. 1. Isolation of the patient should be done when possible
2. Avoid using the patients towel or other fomites
3. Avoid contact with the infected eye as it is highly contagious
4. Patient must keep his hands clean by washing them often.

Question No. 23

a. What is the abnormal finding in this eye?
b. Which vitamin deficiency causes this condition?
c. What is the WHO classification and recommendation to treat this deficiency?



Answer:

a. Bitot Spot
b. Vitamin A deficiency
c. Classification Primary Signs

X1A	Conjunctival Xerosis
X1B	Bitot spots with Conjunctival Xerosis
X2	Corneal Xerosis
X3A	Corneal Ulceration with Xerosis
X3B	Keratomalacia
XN	Night Blindness
XF	Xerofalmia fundus
XS	Corneal scars
XB	Bitot spots

Vitamin – A : 200,000 IU (100,00 IU in < 1 year of age) on day -1, 3 & 14.

Unit 3

SECRETS OF MEDICINE

Question 1

a. What is your diagnosis?
b. Which nerve is affected?
c. Write 2 causes?21
d. Enlist 2 treatment options?

Answer:

a. Bell's Palsy
b. Left 7th Cranial Nerve
c. Parotid tumor, Entrapment in facial canal
d. Physiotherapy, Steroids

Question 2

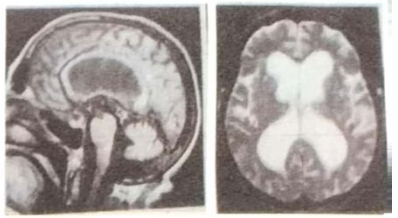
a. Identify the rash and in which disease is Present?
b. Write 2 diagnostic investigations?
c. Name 2 drugs which can be used for treatment of this patient.
d. Write investigations for monitoring the disease?

Answer:

a. Malar Rash , SLE
b. ANA , Anti dsDNA
c. Corticosteroids, Hydrochloroquin
d. dsDNA levels, C3 , C4 levels

Question 3

a. Write name of investigation?
b. Write findings?
c. What is your diagnosis?
d. Write probable causes?



Answer:

a. MRI of brain
b. Diffuse dilatation of lateral third and fourth ventricle
c. Communicating hydrocephalus
d. Scarring of basilar meninges in previous meningitis, SAH, head trauma

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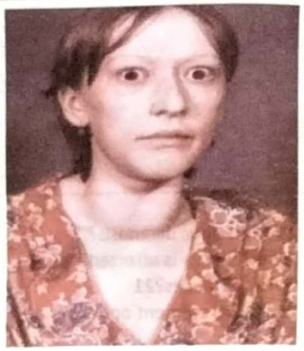
Question 4

a. What is your diagnosis?
b. Name 3 investigations?
c. Name drug treatment?

Answer:

a. Thyrotoxicosis (Grave's disease)
b. Serum TSH, T3, T4, Ultrasound of Thyroid
c. Antithyroid drugs (Propiothiouracil, Methimazole) and Beta Blockers (Propranolol)



Question 5

a. What is your diagnosis?
b. Name 3 important investigations for its diagnosis.
c. Treatment?

Answer:

a. Acromegaly
b. OGTT for diagnosis, IGF1 for screening x-ray skull lateral view, CT/ MRI Brain
c. Bromocriptine, somatostatin analogues Octreotide, Pegvismont, Surgery.

Question 6

a. What is your diagnosis?
b. Write 3 important investigations?
c. Write 3 treatment options?

Answer:

a. RA (Rheumatoid Arthritis)
b. ESR, RA Factor, X ray of hands
c. Analgesics, Corticosteroids, MTX

Question 7

a. What is your diagnosis?
b. Name 2 systemic complications of this disease.
c. Write Investigations?

Answer:

a. Systemic Sclerosis/ Scleroderma
b. Pulmonary fibrosis, Renal crisis
c. ESR, ANA, Anti SCL-70, Anti-centromere Antibody

Question No. 8

a. Identify?
b. Write 5 complications?

Answer:

a. Transfusion bag
b. Transfusion Reactions
a. Early reactions (less than 24 hours)
i. Anaphylaxis
ii. Acute hemolytic reaction
iii. Transfusion associated acute lung injury
iv. Febrile non hemolytic reaction
v. Transfusion associated circulatory overload
b. Late reactions (more than 24 hours)
i. Iron overload
ii. GVHD
iii. Infections (bacterial, protozoa, prion, HIV, hepatitis Virus)

Question No. 9

a. Identify?
b. Name Indications for its use.
c. Name Contraindications.
d. Write down complications with its use?

Answer:

a. Foley's Catheter
b. Urinary output in bed ridden patients, unconscious patient, anesthesia and surgery, therapeutic in retention of urine
And in intravesical chemotherapy, diagnostic urethrogram
c. Acute urethritis, blood at meatus
d. Urinary leak, infections, trauma.

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Question 10

a. Identify.
b. What is indication of its use?
c. Write 2 complications of its use?

Answer:

a. IV cannula of different sizes
b. To maintain IV access
c. Infection, haemorrhage, blockage

Question 11

a. What does the picture show?
b. Write the causes.

Answer:

a. Clubbing
b. **Pulmonary:** Bronchial CA, bronchiectasis, lung abscess, cystic fibrosis, empyema.
Heart: Congenital cyanotic heart disease, infective endocarditis, atrial myxoma.
GIT: Cirrhosis of liver, crohn's disease, ulcerative colitis, celiac disease
Others: Familial, thyroid acropachy.

Question 12

a. What does the picture show?
b. What are the two types
c. Write the causes.

Answer:

a. Ascites
b. Transudative and Exudative
c. **Causes of Transudative Ascites:** Cirrhosis of liver, alcoholic hepatitis, congestive cardiac failure, budd-chiari syndrome, myxedema, portal vein thrombosis, etc.
Causes of Exudative Ascites: Peritoneal carcinomatosis, peritoneal tuberculosis, pancreatic ascites, biliary ascites, etc.

Unit 4

SECRETS OF GYNAECOLOCY OBSTETRICS

Question 1

See the picture carefully and answer the questions

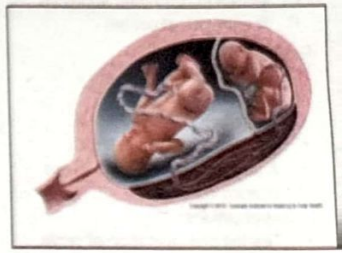
a. What is the condition shown in above picture?
b. What are its complications to fetus?
c. How this condition can be treated?

Answer:

a. Twin transfusion syndrome
b. Complications:
I. Donor twin suffer from
- ✓ Hypovolemia due to blood loss
- ✓ Hypoxia due to placental insufficiency
- ✓ IUGR
- ✓ Oligohydramnios

II. Recipient twin suffer from:
- ✓ Hypervolemia
- ✓ Polyuria and polyhydramnios
- ✓ Myocardial damage
- ✓ High cardiac output failure
- ✓ Some time fetal death

c. Treatment options:
- ✓ Serial amniocentesis every 1-2 weeks with the drainage of large amount of amniotic fluid to prolong pregnancy and improve fetal survival
- ✓ Recently laser coagulation is used to disrupt the placental blood vessels that connect the circulation of the two fetuses.
- ✓ Septostomy



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Question 2

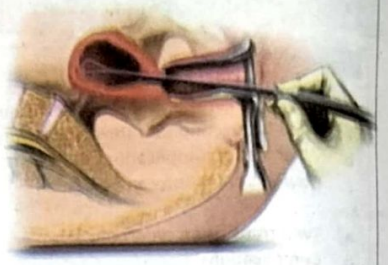
a. What is the procedure shown in picture?
b. Write its indications.
c. Write name of instruments which are used for it?
d. Write complication of this procedure?

Answer:

a. Dilatation and curettage
b. Indications:
- ✓ Abnormal vaginal bleeding
- ✓ Post-menopausal bleeding
- ✓ Missed (incomplete) abortions
- ✓ Therapeutic abortions

c. Instruments Used:
- ✓ Sims speculum
- ✓ Uterine sound
- ✓ Vulsellum
- ✓ Graduated uterine dilator's
- ✓ A pair of narrow ovum forceps
- ✓ Uterine curettes

d. Complications:
- ✓ Tearing and laceration of cervix
- ✓ Perforation of the uterus
- ✓ Peritonitis due to perforation
- ✓ Bowel damage
- ✓ Pelvic cellulitis and parametritis



Question 3

a. What is the diagnosis?
b. Write risk factors?
c. How it can be diagnosed?
d. Write treatment options?

Answer:

a. Fibroid uterus
b. Nulliparity, obesity, a positive family history and African racial origin & 30 yrs of age woman
c. Clinical examination and ultrasound
d. 1. Conservative management- of asymptomatic fibroid

Medical treatment by using a GnRH agonist helpful in shrinking fibroids.

2. surgical treatment, myomectomy or hysterectomy depending upon severity of symptoms, age of patient and fertility desired
3. Uterine artery embolization

Question 4

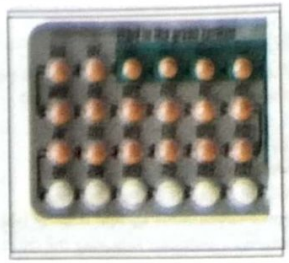
a. What is shown in picture?
b. Explain mode of action?
c. Write Contraindications?

Answer:

a. OCP (oral contraceptive pills)
b. i. inhibition of ovulation by suppressing pituitary release of FSH and LH
ii. Peripheral effects by endometrial atrophy, making sperms ascending difficult into the uterine cavity by thickening of the cervical mucus
c. Absolute Contraindications:
i. IHD
ii. Cerebrovascular accident
iii. Significant HTN
iv. Acute or severe liver disease
v. Focal migraine & breast cancer

Relative Contraindications:

i. Generalized migraine
ii. Long term immobilization
iii. Irregular vaginal bleeding
iv. Smoking
v. Diabetes



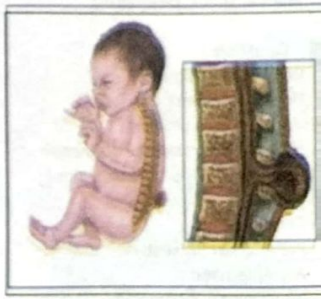
Question No. 5

a. What is the diagnosis?
b. What is the etiology of disease?
c. What are treatment options?
d. What neurological problems Can persist in such babies?

Answer:

a. Spina bifida
b. i. folic acid deficiency
ii.Drugs e.g epileptic drugs
iii.Chromosomal abnormalities
c. Surgical removal of the sac. Prognosis will depend on whether or not the sac contained any nerve roots

Incontinence of the bladder and bowel with gait abnormalities due to involvement of the lower sacral nerves



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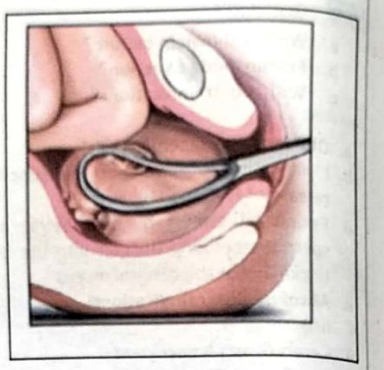
Question 6

a. What is the diagram showing?
b. What is the indications for the use of this instrument?
c. What is the prerequisities for its use?

Answer:

a. Forceps delivery
b. Indications:
i. Delay in the second stage of labour
ii. Fetal distress in the second stage of labour
iii. Maternal conditions requiring the short second stage of labour
iv. Face presentation
v. Bleeding from fetal blood sampling site
vi. After coming head of the breach
vii. Delivery before 34 weeks of gestation
c. Prerequisite:
i. Full dilation of the cervix
ii. Fetal membranes should be ruptured
iii. Presentation vertex, face or after coming head of the breach
iv. Position of the presenting part should be known
v. Head should be engaged at zero station or below
vi. Cephalopelvic disproportion should be ruled out
vii. Bladder should be emptied

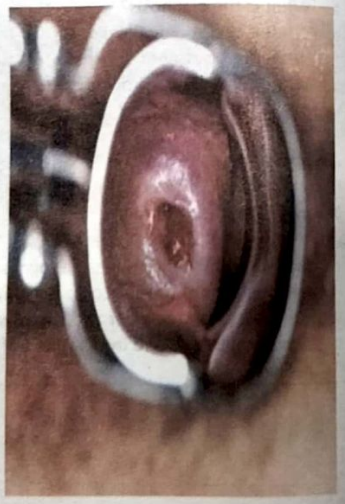


Question 7

a. What is the diagnosis?
b. How the patient can
Present with such problem?
c. How you will make the diagnosis?
d. How you will treat the condition?

Answer:

a. Cervical polyp
b. Patient may present as:
✓ Asymptomatic
✓ Intermenstrual bleeding
✓ Abnormally heavy menstrual bleeding (menorrhagia)
✓ Post-menopausal bleeding
✓ Post Coital bleeding
✓ Thick white vaginal discharge (leucorrhoea)
c. Diagnosis is by:
✓ Speculum examination
✓ Cervical polyp biopsy
d. Treatment:
Surgical removal by ovum forceps or by evulsion of the polyp.



Question No. 8

a. What is the condition shown in figure?
b. What is its etiological factors?
c. What is the treatment options for this condition?

Answer:

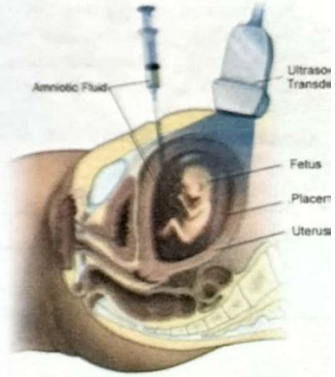
a. Uterovaginal prolapsed
b. i. Menopause, Birth injury
ii. Peripheral nerve injury e.g pudendal nerve
iii. Prolong 2nd stage of labour and excessive bearing down during delivery before full dilatation of the cervix
iv. Ventouse extraction before the cervix fully dilated
v. Delivery of big baby
vi. Spina bifida occulta, split pelvis support
vii. Congenital prolapsed
c. Treatment Options:
1. Conservative:
✓ Perineal floor excercises
✓ Pessary treatment
2. Surgical:
✓ Vaginal hysterectomy with pelvic floor repair
✓ Fothergill's repair (Manchester operation)
✓ Sacrohysteropexy
✓ Lefort's repair

Question No. 9

a. What is the procedure shown in picture?
b. Write indications of this procedure?
c. What are its risks?

Answer:

a. Amniocentesis
b. Indications:
i. Cytogenetic analysis for major aneuploides, the use of fluorescencein-situ hydridization (FISH) can facilitate rapid results with amniocentesis.
ii. DNA analysis for Conditions
1. Haemoglobinopathies like sicke cell disease
2. Cystic fibrosis
3. Fragile x syndrome
4. For Polymerase chain reaction
iii. Biochemical and enzymatic analysis
c. Risks:
i. Miscarriage in 1% of cases
ii. Fetal Trauma
iii. Leakage of amniotic fluid may lead to oligohydramnios
iv. Infection



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Question No. 10

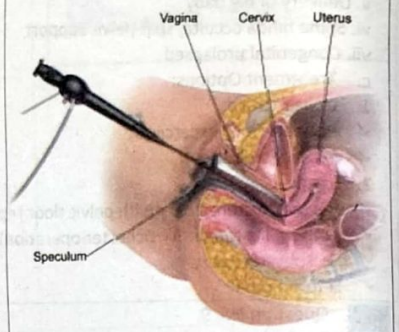
a. What is diagnosis?
b. What is the etiology of this condition?
c. Can it happen in next pregnancy?

Answer:

a. Hydrocephalus
b. Congenital causes, infections and folic acid deficiency
c. Yes, recurrent risk is present

Question No. 11

a. What is the procedure shown in picture?
b. Write its indications?
c. What are its complications?



Answer:

a. Hysteroscope

b. Indications:

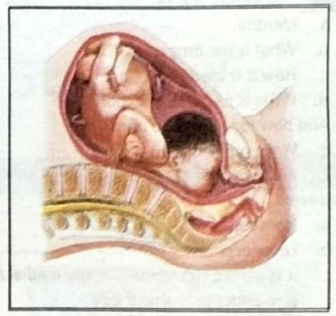
- ✓ Abnormal uterine bleeding
- ✓ Endometrial ablation
- ✓ In unexplained infertility, to evaluate the uterine cavity and cervix
- ✓ Hysteroscopic polypectomy or Myomectomy for submucous fibroid
- ✓ Intrauterine adhesiolysis
- ✓ For diagnosing and treating anomalies like uterine septum, bicornuate uterus, septate uterus, division of a uterine septum (hysteroscopic metroplasty)
- ✓ Sterilization; transcervically with Essure contraceptive tubal occlusion device
- ✓ Removal of an intrauterine device (IUD) under direct visualization

c. Complications:

- ✓ Uterine perforation
- ✓ Hyponatremia
- ✓ Volume overload
- ✓ Cervical trauma during dilatation

Question No. 12

a. What condition is shown in picture?
b. What fetal diameter present in this condition and what is its measurement?
c. How will you diagnose it during labour?
d. How will you deliver baby in such condition?



Answer:

a. Face presentation
b. Submento bregmatic which measures 9.5 cm
c. Diagnosed by palpating the nose, mouth and eyes on vaginal examination
d. Delivery:
i. Vaginal delivery if mento anterior...head delivered by flexion
ii. LSCS if mento posterior ... as further extension of head is not possible

Question No. 13

a. What is shown in figure?
b. How the patient can present with such condition?
c. How will you diagnose this pathology?

Answer:

a. Ovarian tumor
b. Presentation:
- ✓ May be aymptomatic
- ✓ Abdominal pain
- ✓ Abdominal distension
- ✓ Pressure symptoms like nausea. Vomiting, urinary frequency etc
- ✓ Menstrual disturbances
- ✓ Hormonal effects

c. Diagnosis:
- ✓ By pelvic examination if women sexually active
- ✓ USG (abdominal/transvaginal)
- ✓ Doppler USG
- ✓ Serum markers

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Question No. 14

a. Identify.
b. What is the drug used in it?
c. How it is used?
d. What is its mode of action
And how long it can be used?
e. Write advantages?
f. Write disadvantages?

Answer:

a. Norplant
b. Levonorgestril
c. It is placed subdermally in the medial aspect of upper arm under local anesthesia
d. Suppression of ovulation, suppression of endometrium, it provide contraception for 3-5 yrs
e. Advantages:
- ✓ Long acting with sustained effect – compliance is good.
- ✓ Systemic side effects are few and first pass effect on the liver avoided
- ✓ Can be used by lactating mothers and over the age of 40 yrs
- ✓ No 'nuisance' of daily oral or frequent injections

f. Disadvantages:
- ✓ Break through bleeding; irregular cycles
- ✓ Amenorrhea occur as with other progesterone contraceptives
- ✓ Ectopic pregnancy is reported in 1.3%
- ✓ Local infection may occur
- ✓ Expensive

Unit 5

SECRETS OF SURGERY

Question 1

a. Write name of pathology?
b. Write 2 differential diagnosis?
c. Write 2 clinical signs?

Answer:

a. Inguinoscrotal swelling
b. Hydrocele, inguinal hernia
c. Cough impulse, reducibility

Question 2

a. Identify the specimen?
b. What are complications of disease?

Answer:

a. Appendix
b. Appendicular abscess, perforation, Appendicular mass

Question 3

a. What is your diagnosis?
b. What is treatment?
c. Write 2 complications of this condition?

Answer:

a. Sebaceous cyst
b. Excision under local anesthesia
c. Infection, abscess, sebaceous horn

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Question 4

a. What is your diagnosis?
b. How can you confirm your diagnosis?
c. What is the treatment?

Answer:

a. Lipoma
b. FNAC
c. Excision

Question 5

a. What is your diagnosis?
b. Write investigation which is required?
c. What is the most dangerous complication?

Answer:

a. Deep venous thrombosis
b. Color Doppler
c. Pulmonary Embolism

Question 6

a. What is your diagnosis?
b. What are 3 other complications?
c. How would you treat this patient?

Answer:

a. Prolapsed thrombosed haemorrhoides
b. Ulceration, gangrene, fibrosis
c. Conservative treatment

Dilatation followed by haemorrhoidectomy, when edema subsides.

Question 7

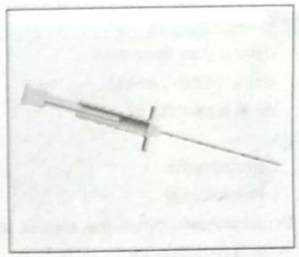
Varicose Veins

Question 8

a. Identify the object?
b. Write 2 indications?
c. Write commonest complication?

Answer:

a. Trucut biopsy needle
b. Liver biopsy, breast biopsy
c. Haemorrhage

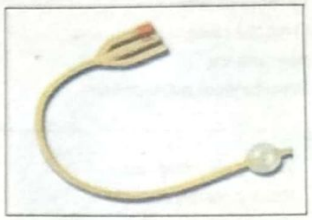


Question 9

a. Identify the object?
b. Write 2 postoperative indications of its use?

Answer:

a. Three way Foley Catheter
b. After prostatectomy, after TURBT



Question 10

a. Identify the condition?
b. What is treatment?

Answer:

a. Pressure Sores (Bed Sores)
b. Prevention is best treatment
   - ✓ Wound debridment
   - ✓ Nutrition
   - ✓ Oxygenation
   - ✓ Flap Coverage

Question 11

a. What is your diagnosis?
b. What is suitable investigation to confirm diagnosis?
c. What is treatment if benign?

Answer:

a. Pleomarphic adenoma
b. FNAC
c. Superficial Parotidectomy

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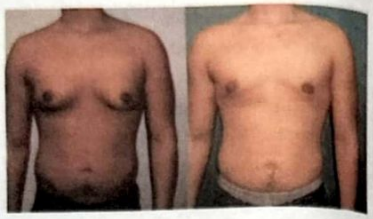
Question 12

a. What is your diagnosis?
b. Write various causes?
c. What is treatment?



Answer:

a. Gynecomastia
b. i. Physiological
ii. Drugs: steroids, cimetidine, digoxin, spironilactone
iii. Androgen deficiency
iv. Testicular tumor
v. Cirrhosis of liver
c. Treat the cause
Reassurance
Subcutaneous mastectomy

Question 13

a. What is your diagnosis?
b. Write 2 complications?
c. What is treatment?

Answer:

a. Cystic hygroma
b. Infection, respiratory obstruction
c. Excision

Question 14

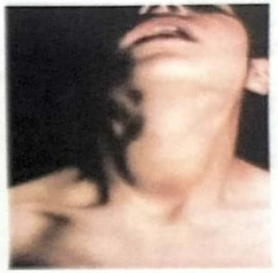
a. Identify item.
b. Name 2 sites which it is commonly used.
c. Name 3 methods of maintaining intravenous line.
d. Name 2 IV fluids used routinely?
e. Give 2 complications of this object.

Answer:

a. Branula
b. Basilica vein, cephalic vein
c. Intravenous branula
Central venous line
Peripheral inserted central (PIC) line
d. Normal saline, Ringer Lactate, Dextrose
e. Thrombophlebitis, thromboembolism

Question 15

a. Give 2 likely diagnoses.
b. If a near thyroidectomy has been done. What hormonal consequence can occur postoperatively?
c. If this girl complains of circumoral numbness, what other sign would you like to elicit?



Answer:

a. Primary thyrotoxicosis, puberty goiter
b. Hypothyroidism
c. Chvostek's sign

Question 16

a. What is probable diagnosis?
b. Name 3 investigations to proceed for management?
c. Write 3 indications of surgery?

Answer:

a. Multinodular goiter
b. Serum TSH, T3, T4
c. Thyrotoxicosis, retrosternal extension leading to obstructive symptoms, suspicion of malignancy, cosmesis

Question 17

a. What is your diagnosis?
b. What investigations would be needed for further management?
c. Write treatment?

Answer:

a. Carcinoma tongue
b. Incisional biopsy, X-ray, MRI
Surgery, Radiotherapy

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Question 18

a. Identify the lesion.
b. What is rule of nine?
c. How will you calculate fluid in 1st 24 hours?
d. What are complications?

Answer:

a. Superficial burn

b.

- ✓ Upper limb 9% each
- ✓ Head and face 9%
- ✓ Lower limb 18% each
- ✓ Front of chest 9%
- ✓ Back of chest 9%
- ✓ Front of abdomen 9%
- ✓ Back of abdomen 9%
- ✓ 1% perineum

c. Parkland formula

d. Infection, keloids, shock, respiratory distress, contractures, Hypertrophic scars

Question 19

a. What is your diagnosis?
b. What type of gangrene usually develops in diabetes?
c. How will you manage diabetic foot?

Answer:

a. Diabetic foot, ulcer on foot
b. Wet gangrene
c. i. Routine worksup including X Ray foot for osteomyelitis
i. Control of Blood sugar (oral hypoglycemic & insulin)
ii. Wound debridment
iv. Amputation if bone involved

Question 20

a. Write 2 features which you would look for during palpation?
b. Write 2 important investigations which you would perform?
c. What is the probable diagnosis?
d. If it is a carcinoma how would you treat it?

Answer:

a. Presence of lump in breast and axillary lymph nodes
b. Mammography, edge biopsy of ulcer or FNAC
c. Ulcerated CA breast
d. Modified radical mastectomy after staging the disease

Question 21

a. What is your diagnosis?
b. What signs would you look for and how would you elicit them?
c. What complications can occur?
d. What are signs of strangulation?

Answer:

a. Paraumbilical hernia
b. Reducibility, cough impulse
c. Irreducibility, intestinal obstruction strangulation
d. Tense, tender, continuous pain, recent increase in size, irreducibility, no cough impulse

Question 22

What is your diagnosis?

Answer:

Neurofibromatosis

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Question 23

a. Write 4 different neoplasms of thyroid gland?
b. Write surgical treatment of thyroid malignancy in high risk group?
c. Write 5 possible operative complications of thyroid surgery?
d. What is the treatment option for solitary distant bony metastasis of thyroid malignancy

Answer:

a. Thyroid adenoma, Papillary carcinoma Follicular carcinoma, Medullary carcinoma, Anaplastic
b. Total thyroidectomy
c. Haemorrhage, tension hematoma, recurrent laryngeal nerve damage, Parathyroid insufficiency, Thyroid insufficiency
d. Radio-ablation

Question 24

a. What is the type of wound?
b. What are different types of wound healing?
c. Write 5 factors that promote wound healing?
d. Write 5 factors that delay wound healing?

Answer:

a. Incised wound
b. i. First intention healing
. Second intention healing
. i. Good blood supply
. Absence of infection
i. Wound edges in opposition
. Good nutrition
. Vitamin C
. i. Anemia
ii. Poor blood supply
iii. Poor nutrition
iv. Infection
v. Foreign body

Unit 6

OSPE-PAEDIATRICS

Question 1

1: Identify the two diagnostic tests performed for the diagnosis of Tuberculosis. (2)
2. Which is more significant. (1)
3. Name four conditions in which these tests false negative. (2)

Key::

1-
- ✓ Tuberculin test (Mantoux test) on fore arm (1)
- ✓ Accelerated BCG tests on the upper arm (1)

2. Accelerated BCG test
3. (0.5 each for any 4 out of 5)
- ✓ Severe malnutrition
- ✓ Miliary tuberculosis
- ✓ Tuberculous meningitis
- ✓ Immunocompromised patient
- ✓ Patient on steroids / chemotherapy

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Question 2

1: Which common infectious disease can lead to this deformity? (1)

2: Name four diagnostic investigations (2)

3: Name four drugs along with dosage & duration. (2)

Key:

1- Carries spine / Tuberculous spine (1)

2- (0.5 each)

- ✓ Mantoux test / Accelerated BCG test
- ✓ X-ray chest
- ✓ X-ray spine
- ✓ CT Scan spine

3- (0.5 each)

- ✓ Rifampicin orally 10-20 mg/kg OD before breakfast for 1 yr
- ✓ Isonazid 10-20 mg/kg/day OD for 1 yr.
- ✓ Pyrazinamide orally, 15-30 mg/kg/day for initial 2M
- ✓ Ethambutol (10- 15 mg/kg/day) or Inj. Streptomycin (30-40 mg/kg/day x I/M x OD) for initial 2 months

Question 3

1: What are the findings? (1)

2: Give three differential diagnosis? (1.5)

3: Give the steps of treatment of the most common chronic infectious disease responsible for these findings? (2.5)

Key:

1- (0.5 each)

- ✓ Gross Ascities
- ✓ Gross emaciation

2. (0.5 each)

- ✓ Abdominal Tuberculosis
- ✓ Chronic liver disease
- ✓ Malignancy (Lymphoma)

3-

i. Fluid & Salt restriction. (0.5)

ii. Nutritional rehabilitation. (0.5)

iii. Chemotherapy for tuberculosis (1.5)

- ✓ Rifampicin orally 10-20 mg/kg OD before breakfast for 1 yr
- ✓ Ionized 10-20 mg/kg/day OD for 1 yr.
- ✓ Pyrazinamide orally, 15-30 mg/kg/day for initial 2M
- ✓ Ethambutol (10- 15 mg/kg/day) or Inj. Streptomycin (30-40 mg/kg/day x I/M x OD) for initial 2 months

Question 4

1: What will you find on abdominal examination as shown in this photograph?(1)

2: Name three common diseases responsible for these findings? (1.5)

3: Describe the laboratory tests required for the diagnosis of above those three diseases? (2.5)

Key:

1- Hepatosplenomegaly

2- (0.5 each)

- ✓ Malaria
- ✓ Typhoid fever
- ✓ Tuberculosis / Hepatitis

3- (0.25 each for 10 out of 11)

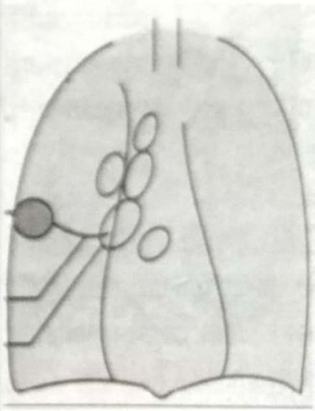
- ✓ Hb, TLC, DLC, ESR
- ✓ Malarial parasites thick & thin film slides
- ✓ ICT for malarial parasite
- ✓ Tuberculin test / accelerated BCG test
- ✓ X-ray chest (PA view)
- ✓ Blood culture for S. typhi & Para typhi
- ✓ Widal test / typhidot test
- ✓ Sputum for AFB
- ✓ Stool culture
- ✓ Urine culture
- ✓ Bone marrow examination & culture

Question 5

1: Identify the pathological pulmonary lesions shown in photograph? (1.5)

2: What is the clinical conditions? (1)

3: Enumerate the 10 complications / sites of extra pulmonary involvement of this infectious condition. (2.5)



Key:

1- Primary complex comprised by lymph nodes, lymphatics & ghon focus (1.5), 0.5 each.

2- Pulmonary Tuberculosis (1)

3- (0.25 each)

- ✓ Miliary tuberculosis
- ✓ TBM
- ✓ Pneumonia
- ✓ Pleural effusion

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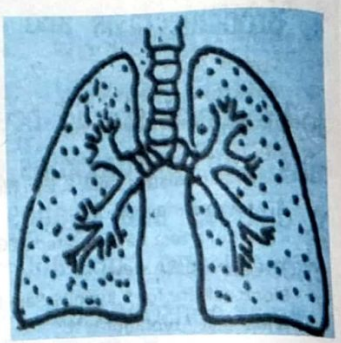
- ✓ Atelectasis
- ✓ Pneumothorax
- ✓ Abdominal tuberculosis
- ✓ Carries spine
- ✓ Bronchiectasis
- ✓ Pericarditis

Question 6

1. What is the radiological diagnosis? (1)
2. What are three other conditions in Pediatrics leading to such infiltrations on x-ray chest?
3. What are five common findings on clinical examination?



Key:

1- Miliary Tuberculosis / mottling (1)

2- (0.5 each)

- ✓ Atypical pneumonia
- ✓ Fungal pneumonia
- ✓ Viral pneumonitis

3- (0.5 each)

- ✓ Emaciation
- ✓ Hepatosplenomegaly
- ✓ Choroid tubercles in eyes
- ✓ Respiratory distress, rales & rhonchi
- ✓ Generalized lymphadenopathy

Question 7

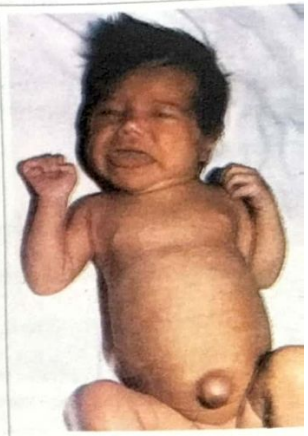
Q1: What is the diagnosis?(1)
Q2: What are the etiological organisms?(2)
3: What is the treatment.(2)

Key:

1- Tinea corporis(1)
2- i. T. rubrum
ii. T. mentagrophytes
iii. M. canis
3- Topical antifungal agents(1) (Miconazole, Clotriamazole)
Oral antifungal agents(1) (Griseosulvin)

Question 8

1: What is the diagnosis? (0.5)
2: Describe 12 clinical features of this condition. (3)
3: Name two diagnostic tests and the drug for treatment? (1.5)



Key:

1- Congenital hypothyroidism / Cretinism (0.5)

2- (0.25 each)

- ✓ Coarse facies
- ✓ Broad nasal bridge.
- ✓ Flaccid / contended baby
- ✓ Umbilical hernia
- ✓ Large tongue
- ✓ Low hair line
- ✓ Dry skin
- ✓ Distended abdomen
- ✓ Constipation
- ✓ Short stature
- ✓ Delayed dentition
- ✓ Delayed milestones
- ✓ Anemia

3- Lab Tests: (0.5 each)

- ✓ Serum free T4
- ✓ Serum TSH

Drug: Thyroxin (4 – 15 µg/kg/day OD orally) (0.25)

Question 9

1: What is the clinical finding? (1)
2: Name the two underlying conditions leading to this finding? (2)
3: What is the management? (2)

Key::

1- Noma / Cancrum oris (1)

2- (1 each)

- ✓ Measles
- ✓ Malnutrition 3- (0.25 each)
- ✓ Nutritional rehabilitation
- ✓ Cap. Vitamin A
- ✓ Vitamins B-Complex
- ✓ Vitamin C
- ✓ Iron
- ✓ Antibiotics
- ✓ Ampicillin & Metronidazole
- ✓ Plastic surgery

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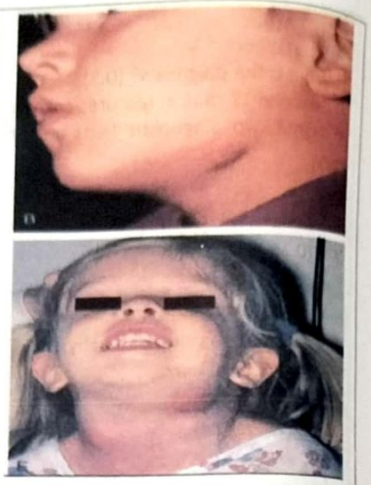
Question 10

1: What is the diagnosis? (1)
2: Describe four causes of this condition. (2)
3: Describe four investigations to reach the diagnosis. (2)

Key:
1- Cervical lymph adenitis (1)
2-(0.5 each)
- ✓ Tuberculous lymph adenitis
- ✓ Bacterial / suppurative lymph adenitis
- ✓ Malignancy
- ✓ Non-specific / viral / Atypical micro bacteria tuberculosis

3- (0.5 each)
- ✓ CBC including peripheral morphology & ESR
- ✓ X-ray chest
- ✓ Tuberculin test /BCG accelerated tests
- ✓ FNA / Excisional biopsy / Aspiration



Question 11

1: What is the clinical finding? (1)
2: What are three common differential diagnosis? (1.5)
3: Write down the treatment steps of the most likely diagnosis. (2.5)

Key::
1- Edema of the face, more around the eyes (Nephrotic syndrome) (1)
2- (0.5 each for any 3 out of 4)
- ✓ Nephrotic syndrome
- ✓ Cirrhosis of liver.
- ✓ Acute nephritis
- ✓ CCF

3- Treatment:
(i) General supportive treatment (1)
Diet, Diuretics, infection prevention & treatment.
(ii) Specific treatment (1)
Corticosteroid therapy, Cyto-toxic therapy.
(iii) Counseling to the parents & Follow up (0.5)

Question 12

1: What is the abnormal finding? (1)
2: What is the diagnosis & Etiology? (2)
3: What is the treatment? (2)

Key::
1- Multiple Bullous / Pustular & ulcerative lesions over the anterior abdominal wall, thigh & scrotum. (1) 2-
- ✓ Impetigo (1)
- ✓ Group A streptococcal infection, (0.5) Staphylococcus aureus infection. (0.5)

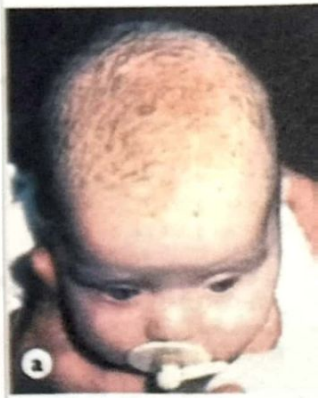
3- Treatment:
(i) Local Measures
Improvement of personal hygiene (0.5)
Wash with antibacterial soap (0.5)
(ii) Topical therapy
Antibiotic cream such as mupirocin (0.5) Penicillin, Erythromycin or Cephalosporin (0.5)

Question 13

1: What is the abnormality & what areas are commonly affected?
2: What is the diagnosis? (1)
3: What is the treatment? (2)

Key:
1- Cradle cap (0.5)
(0.5 each for any 3 out of 5)
- ✓ Scalp
- ✓ Face
- ✓ Behind the ears
- ✓ Flexures
- ✓ Nappy area

2- Infantile Seborrhoeic dermatitis (1)
3-
- ✓ Improve hygiene (0.5 each for any 4)
- ✓ Anti-seborrhoeic shampoo (Selenium sulfide, Sulfur, Salicylic acid, Tar)
- ✓ Topical corticosteroid therapy
- ✓ 3% sulfur ointment
- ✓ Topical anti-fungal agent



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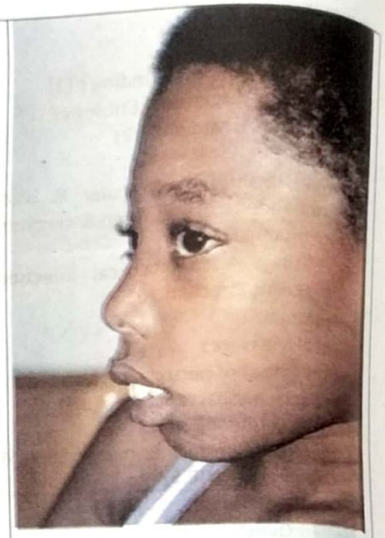
Question 14

1: What type of abnormal facies/finding are present? (0.5)
2: What is the diagnosis? (1)
3: What is the steps of management? (3.5)

Key:

1- Thalassemic facies / Maxillary prominence & protrusion of teeth due to enlargement of marrow cavity in condition of decrease red blood cells survival.
2- Hemolytic anemia especially B-Thalassemia major. (1)
3-

- ✓ General Supportive treatment (0.5) Nutritional & Hygienic measures
- ✓ Blood Transfusion therapy: (0.5) Top up transfusion,
- ✓ Hyper Transfusion, Super transfusion.
- ✓ Chelation therapy (0.5)
- ✓ Splenectomy (0.5)
- ✓ Bone marrow transplantation (0.5)
- ✓ Genetic Counseling (1)



Question 15

1: What is the diagnosis of this night time itchy disease? (1)
2: What is the etiology? (1)
3: What is the treatment? (3)

Key:

1- Scabies (1)
2- Sarcoptes Scabies (1)
3- (i) General (1) (0.5 each)

- ✓ Clothing should be laundered
- ✓ All family members should be Treated simultaneously

(ii) Topical (2) (1 each)

- ✓ Permathrin cream 5%
- ✓ 6% Sulfur in petrolatum.

Question 16

1: What is the diagnosis? (1)
2: What are the complications? (2)
3: What is the treatment? (2)

Key:

1- Collodion baby (1)
2- (0.5 each)

- ✓ Cutaneous infections
- ✓ Aspiration pneumonia
- ✓ Hypothermia
- ✓ Hypernatremic dehydration

3- (1 each)

- ✓ High humidity environment
- ✓ Application of non occlusive lubricants

Question 17

1. Identify 4 positive findings in this picture & what is the diagnosis.(2.5)
2. How antenatal diagnosis of this condition is made. (1.5)
3. What is the risk of recurrence in next pregnancy. (1)

Key::

1- (0.5 each for any 3 out of 4)

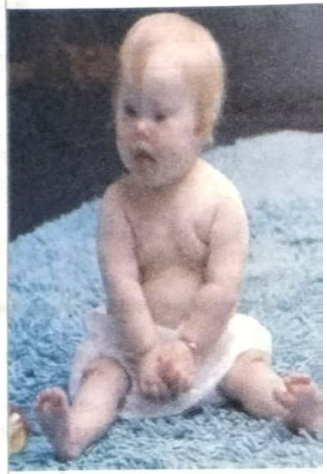
- ✓ Up slanting of eyes / Palpebral fissure
- ✓ Depressed bridge of nose
- ✓ Hypotonia
- ✓ Protruding tongue with open mouth Diagnosis: Down Syndrome(1)

2- (0.5 each)

- ✓ Decreased AFP, decreased Estriol, increased HCG
- ✓ Chromosomal analysis of fetal cells either by Amniocentesis or by CVS.
- ✓ Ultrasound scanning increased nuchal translucency

3- (0.5 each for any 2 out of 3)

- ✓ If non-disjunction as underlying cause ⍰ recurrence risk 1%
- ✓ If translocation: 21/21 then risk is 100%
  If 14/21 translocation, then risk is 10-15% (3-5%)
  If translocation at 21/22, then risk is 10-12% (5%)
- ✓ If Mosaicism: risk is 1%



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Question 18

1: Give the diagnosis in the pictures. (1)
2: What is crossed and uncrossed hemiplegia. (2)
3: Give difference between upper motor neuron lesions & lower motor neurons. (2)

Key::

1- Facial (7th cranial nerve) palsy. (1)

2-

a. Crossed hemiplegia
- ✓ Cranial nerve of one side & Hemiplegia on other side (0.5)
- ✓ Lesions is in brain stem (0.5)

b. Uncrossed Hemiplegia
- ✓ Cranial nerve of same side & Hemiplegia of same side (0.5)
- ✓ Lesions is above the brain stem (usually in internal capsule) (0.5) 3- (0.5 for any 4 out of 6)

	UMN Lesion	LMN Lesion
Bulk	Normal	Decreased
Fasciculations	Absent	Present
Tone	Increased	Decreased
Power	Decreased	Decreased
Reflexes	Brisk	Absent/Diminished
Planter reflex	Up going	Down going
Clonus	Present	Absent

Question 19

1: Identify one positive finding in each picture? (1.5)
2: Enumerate 6 causes of above disease? (3)
3: What is treatment of choice in above disease? (0.5)

Key::

1-
- ✓ Large head. (0.5 each)
- ✓ Sunset sign
- ✓ Ventricular dilatation (Hydrocephalus)

2-
- ✓ Congenital aqueductal stenosis (0.5 each for any 6 out of 8)
- ✓ Dandy walker malformation iii.Arnold chiari malformation Type II iv.Congenital Torchs infections
- ✓ Bacterial meningitis vi.TBM
- ✓ Arachiniditis secondary to bleeding in subarachnoid space viii.IVH in premature infant

3- Ventriculo-peritoneal shunt. (0.5)

Question 20

1- What are the abnormal findings? (1)
2- What is the diagnosis? (0.5)
3- Write down the management steps. (3.5)

Key::

1-
- ✓ Emaciated irritable child / wizened face / prominent rib cage (0.5)
- ✓ Loss of fat over the buttocks / body.(0.5)

2- Marasmus (0.5)

3- Initial management (1.5)
- ✓ Life-threatening problems are identified and treated in the hospital
- ✓ Specific deficiencies are corrected
- ✓ Metabolic abnormalities are corrected
- ✓ Feeding is begun

Rehabilitation (1)
- ✓ Intensive feeding is given to recover most of the lost weight
- ✓ Emotional and physical stimulation are increased
- ✓ Training of the mother
- ✓ Preparations for the discharge

Follow up (0.5)

Counseling of mother & family (0.5)

Question 21

1- What are 4 positive findings in this picture? (2)
2- What is the diagnosis? (1)
3- What are the causes which lead to this condition? (2)

Key::

1- Puffy moon face
- ✓ Miserable looking and apathetic
- ✓ Flaky paint dermatitis
- ✓ Edema feet

2- Kwashiorkor (1)

3- **Primary malnutrition** (1) (0.25 each for any 4 of the 5)
- ✓ Failure of lactation
- ✓ Ignorance of weaning
- ✓ Poverty
- ✓ Cultural pattern and food fads
- ✓ Lack of immunization
- ✓ Lack of family planning

Secondary malnutrition (1) (0.25 each for any 4 of the 5)
- ✓ Infections
- ✓ Congenital diseases
- ✓ Malabsorption
- ✓ Metabolic and psychosocial deprivation

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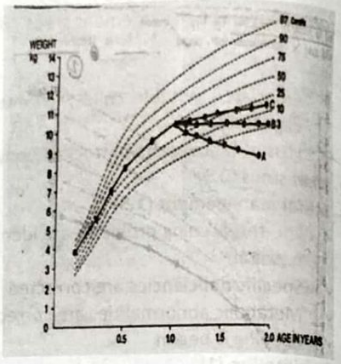
Question 22

What definition this graph reflects. (1)
Enumerate 8 common causes of this condition. (2)
Enumerate 8 steps to prevent malnutrition in children.(2)



Key::

Failure to thrive
(0.25 each for any 8 of 10)

- ✓ Failure of lactation
- ✓ Faulty weaning
- Poverty / ignorance
- Cultural food patterns
- Lack of immunization/family planning and primary care
- Recurrent GIT infections
- Recurrent respiratory tract infection
- Measles / malaria
- Tuberculosis
- Congenital malformation

(0.25 each for any 8 of 11)

- Optimum breast feeding
- Avoiding bottle feeding, pacifiers etc.
- Adequate weaning
- Immunization
- Growth monitoring
- Family planning
- Health education
- Safe water and food supply
- Personal and environmental hygiene
- Adequate application of national programmes like CDD & ARI
- Improvement of literacy rate and socioeconomic condition

Question 23

1- What are the complications of bottle feeding? (2)
2- Enumerate benefits of breast feeding? (2.5)
3 – Write 2 absolute contraindications of breast feeding.(0.5)

Key::

1-

- ✓ Repeated GIT infections (0.5)
- ✓ Repeated respiratory infections (0.5)
- ✓ Expensive (0.5)
- ✓ Difficult to maintain good Hygiene (0.5)

2- (0.25 each for any 10 out of 11)

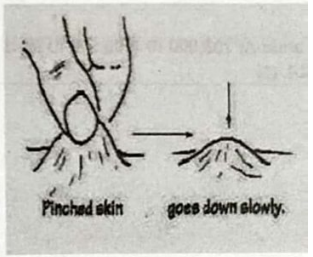
- ✓ Inexpensive
- ✓ Available all the time
- ✓ Composition is ideal for infant growth
- ✓ Emotionally satisfactory
- ✓ Bifidus factor which promote the growth of lactobacillus
- ✓ Promotes involution of the uterus
- ✓ Natural contraception
- ✓ Decreased incidence of breast cancer
- ✓ Lactoferin
- ✓ Species specific, no allergy
- ✓ Decreased incidence of infections

3- (0.25 each)

- ✓ Galactosemia
- ✓ Phenylketonuria

Question 24

1- What is the sign shown in the figure? (1)
2- Write down 4 other signs of this condition? (2)
3- Write down the management steps of this condition according to WHO protocol? (2)



Key::

1- To check skin turgor in dehydration. (1)
2- (0.5 each)

- ✓ Lethargic or unconscious
- ✓ Sunken eyes
- ✓ Not able to drink or drinking poorly
- ✓ Pulses weak or absent

3-

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Age	First give 30ml/kg in:	Then give 70ml/kg in:
Infants (<12 months)	1hour	5hours
Children 12 months upto 5 yrs	30 min	2 ½ hours

ORS/Home Made Remedies

Question 25

1- What is the abnormal finding in this eye? (1)
2- Which vitamin deficiency causes this condition?(1)
3- What is the WHO classification and recommendation to treat this deficiency? (3)

Key::
1- Bitot spot (1)
2- Vitamin A deficiency (1)
3- (2) (0.25 each for any 8 out of 9)

Classification	Primary signs
XK1A	Conjunctival xerosis
XK1B	Bitot spots with conjunctival xerosis
X2	Corneal xerosis
X3A	Corneal ulceration with xerosis
X3B	Keratomalacia
XN	Night blindness
XF	Xerophalmia fundus
XS	Corneal scars
XB	Bitot spots

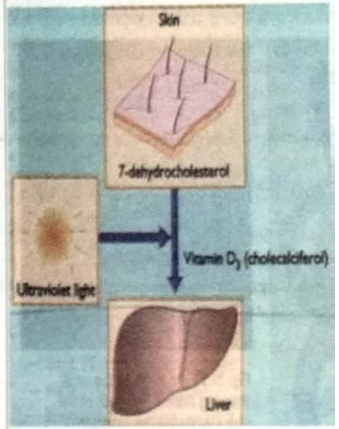
Vitamin-A: 200,000 IU (100,000 IU in <1 year of age) on day-1,3 & 14. (1)

Question 26

1: Name the final step in formation of Vitamin D. (2)
2: Name 6 common causes of rickets. (1.5)
3: Name 6 common clinical features of rickets. (1.5)

Key::
1- Renal activation of 25-Hydroxy cholicalciferol
With the help of 1-alpha hydroxylase to form 1, 25-Hydroxy cholicalciferol (2)
2- (0.25 each for any 6 out of 8)
- ✓ Nutritional rickets
- ✓ Vitamin D dependent rickets
- ✓ Vitamin D resistant rickets
- ✓ Rickets due to malabsorption
- ✓ Rickets due to chronic anticonvulsant therapy
- ✓ Hepatic
- ✓ Renal
- ✓ Hypophosphatemic rickets

3- (0.25 each for any 6 out of 7)
- ✓Head large with frontal bossing
- ✓Delayed eruption of teeth with defective enamel
- ✓Thorax (Rachitic rosary, Harrison's sulcus, pigeon chest deformity)
- ✓Spine (Kyphosis, scoliosis, lordosis)
- ✓Pelvis (Contracted pelvis)
- ✓Extremities (widening of the end of long bone, genu valgum or genu varus deformity)
- ✓Miscellaneous (Hypotonia and potbelly, laxity of ligaments, short stature, tetany)



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Question 27

1- What are the findings in the pictures?(1.5)
2- What is the diagnosis?(1)
3- What is the treatment?(2.5)

Key::

1. Picture 1

Widening, Cupping, and fraying of the ends. (0.5 each)

2- Rickets

3- (0.5 each)

- ✓ Vitamin-D_3 (Either oral or intramuscular injection)
- ✓ Calcium supplementation
- ✓ Vitamin-D dependent rickets; 1,25- $(OH)_2$ -D_3
- ✓ Diet high in Calcium & vitamin D
- ✓ Exposure to sunlight

Question 28

1: What is the abnormal finding? (1)
2: What is the diagnosis & complications? (2)
3: What is the treatment? (2)

KEY::

1- Bilateral grayish membrane on tonsils with surrounding hyperemia (0.5)

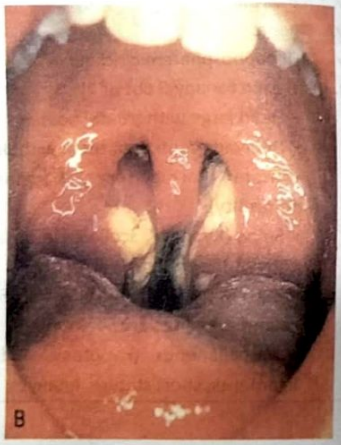
2- Diagnosis: Pharyngeal diphtheria (0.5)

Complications: (0.5 each)

- ✓ Myocarditis
- ✓ Toxic polyneuritis
- ✓ Broncho pneumonia
- ✓ Miscellaneous (Hepatitis, Nephritis, adrenal hemorrhage, gastrititis)

3. (0.5 each)

- ✓ Diphtheria antitoxin
- ✓ Antibiotics (Penicillin & Erythromycin)
- ✓ Supportive intervention directed at complications
- ✓ Strict isolation



Question 29

1- What are the different methods to prevent neonatal tetanus? (2)
2 - Write down the management steps of neonatal tetanus. (3)

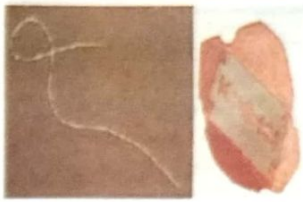
Key::

1-

- ✓ Conduct the delivery in the hospital (0.25)
- ✓ Strict aseptic techniques as washing of the hands, sterilized instruments & Lenin, (0.25)
- ✓ Five dose Immunization schedule (1.5)

2-

- ✓ Sedation (0.5)
- ✓ Feeding (0.5)
- ✓ Nursing care (0. 5)
- ✓ Antitoxin (ATS, TIG) (0.5)
- ✓ Antibiotics (Benzyl penicillin to kill vegetative C.tetani (0. 5)
- ✓ Counseling 0.25)
- ✓ Follow up (0.25)



Question 30

1- What are abnormal findings in this baby. (2)
2- What is the diagnosis? (1)
3- What are the management steps of this condition. (2)

Key::

1-

- ✓ Risus sardonicus / Lockjaw (1)
- ✓ Generalized spasm & (1)

2- Tetanus neonatorum (1)

3-

- ✓ Sedation (0.25)
- ✓ Feeding (0.25)
- ✓ Nursing care (0.25)
- ✓ Antitoxin (ATS, TIG) (0.5)
- ✓ Antibiotics (Benzyl penicillin to kill vegetative C.tetani (0.25)
- ✓ Counseling 0.25)
- ✓ Follow up (0.25)

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Question 31

1- What is the abnormal finding & diagnosis? (1)
2- What are the steps of management? (2)
3- How can you eliminate this disease in the neonate? (2)

Key::

1- Risus sardonicus / Lockjaw & Tetanus neonatorum (0.5 each)

2-

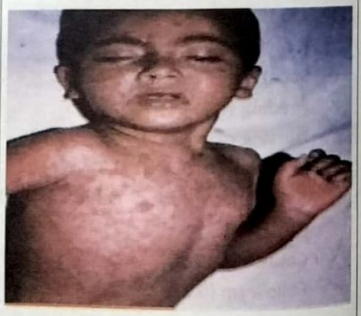
- ✓ Sedation (0.25)
- ✓ Feeding (0.25)
- ✓ Nursing care (0.25)
- ✓ Antitoxin (ATS, TIG) (0.5)
- ✓ Antibiotics (Benzyl penicillin to kill vegetative C.tetani
- ✓ Counseling 0.25)
- ✓ Follow up (0.25)

3-

- ✓ 5 dose schedule of TT to mother (1)
- ✓ 5 Cs (1)

Question 32

1- What is the type of rash & what is diagnosis? (1)
2- Write 6 conditions which produce such type of skin irruption. (1.5)
3- What are 10 complications of the most likely diagnosis? (2.5)



Key::

1- Maculopapular rash (0.5), Measles (0.5)

2- Measles

- ✓ Rubella
- ✓ Scarlet fever
- ✓ Typhoid fever
- ✓ Roseola infantum
- ✓ Erythema infectiosum

3 - (0.25 Each)

- ✓ Otitis media
- ✓ Pneumonia
- ✓ Encephalitis
- ✓ Hemorrhagic measles
- ✓ Gastroenteritis
- ✓ Myocarditis
- ✓ Immuno suppression
- ✓ SSPE (Subacute sclerosing pain encephalitis)
- ✓ Post measles state
- ✓ PEM

Question 33

1- What is the diagnosis of this vaccine preventable infectious condition (1)
2- How can you prevent this condition by immunization. (2)
3- Write 8 complications of this disease. (2)

Key::

1- Mumps (1)

2- By MMR vaccine at 15 months and before school entry (1 each)

3- (0.5 for any 8)

- ✓ Meningoencephalomyelitis
- ✓ Epididymo-orchitis
- ✓ Pancreatitis
- ✓ Deafness
- ✓ Oophoritis
- ✓ Thyroiditis
- ✓ Myocarditis
- ✓ Arthritis
- ✓ Thrombocytopenia

Question 34

1- What is the abnormal finding? (1)
2- What are three differential diagnosis? (1.5)
3- What are the complications of the most probable diagnosis? (2.5)

Key::

1- Bilateral grayish membrane on tonsils with surrounding hyperemia (1)

2- Diphtheria (0.5)

- ✓ Acute tonsilitis (0.5)
- ✓ Infectious mono-nucleosis (0.5)

3- (0.5 each)

- ✓ Myocarditis (10-25%)
- ✓ Toxic polyneuritis (10-20%)
- ✓ Broncho pneumonia
- ✓ Hepatitis, Gastritis
- ✓ Nephritis, Adrenal hemorrhage.

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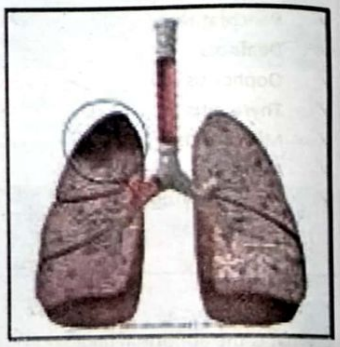
Question 35

1- What are the figures show? (1)

2- What are different mode of transmission of infectious diseases? (2)

3- Write the treatment of pulmonary tuberculosis? (2)



Key::

1- (0.5 each)

i. Droplet infection
ii. Right apical involvement of pulmonary tuberculosis

2- (0.5 each)

i. Droplet infection
ii. Sexual route
iii. Needle pricks
iv. Fecoral route

3-

General supportive (0.5)

i. Hygienic and nutritional care
ii. Screening of the family

Specific treatment

i. Isonazid
ii. Rifampicin
iii. Pyrazinamide
iv. Ethambutol / Streptomycin (depending upon the severity of the infection such as millary and disseminated tuberculosis)

Counseling (0.25)

Follow up (0.25)

Question 36

1. Write two positive findings in the picture? (1)

2: Write three common differential diagnosis. (1.5)

3: Write the management steps of the most common acquired bleeding disorder of childhood. (2.5)

Key::

1-

i. Purpuric rashes on the feet (0.5)
ii. Subconjunctival hemorrhage (0.5)

2-

D/D: (i) ITP (0.5)
(ii) Leukemia (0.5)
(iii) Aplastic anemia (0.5)

3-

Supportive measures (0.5)

i. Prevention of trauma
ii. Restrict physical activity
iii. Avoid antiplatelet medication
iv. Platelet transfusion

Pharmacological treatment 1 (0.5 for any two out of three)

i. IVIG
ii. Anti-Rh-D
iii. Steroids

Management of chronic ITP (0.5)

As above + Splenectomy with Pneumococcal, meningococcal and HIB vaccination

Counseling (0.25)

Follow up (0.25)

Question 37

1- Write down the positive findings in the pictures. (0.5)

2- Which inherited bleeding disorder causes such swelling & what is the inheritance. (1)

3- Write down the management steps of this condition. (3.5)

Key::

1- Swollen knee joints / Heamarthrosis (0.5)

2-

i. Hemophilia (0.5)
ii. X-linked recessive (0.5)

3-

General supportive management (0.5)

i. Prevention of trauma
ii. Avoid aspirin
iii. Immunization against hepatitis-B

Pharmalogical treatment (2) (0.5 for any 4)

i. Desmopressin
ii. Aminocaproic acid
iii. Tranexamic acid
iv. FFP, Cryoprecipitate
v. Administration of Factor VIII concentrate

Counseling (0.5)

i. General counseling to the parents
ii. Genetic counseling

Follow up (0.5)

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Question 38

Q.1Which cranial nerve is paralyzed in the picture. (1)

Q 2 Enumerate 8 other clinical findings in such a patient. (2)

Q 3 Name 8 causes of this condition in children. (2)

Key::

1- Facial nerve palsy (1)

2- (0.25 each)

- ✓ Loss of frowing of forehead
- ✓ Loss of closure of the eye
- ✓ Loss of nasolabial fold
- ✓ Collection of food particle on the affected side
- ✓ Deviation of the angle of the mouth to the opposite side
- ✓ Whistling is inappropriate
- ✓ Loss of taste of anterior 2/3rd of the tongue
- ✓ Hyper acusis

3- (0.25 each for any 8 out of 9)

- ✓ Idiopathic (Bell's palsy)
- ✓ Acute or chronic otitis media
- ✓ Temporal bone fracture
- ✓ Herpes zoster oticos
- ✓ Pyo-meningitis
- ✓ Encephalitis
- ✓ Tuberculous meningitis
- ✓ Brain tumor
- ✓ Intracranial hemorrhage

Question 39

1- What is the abnormality visible on the two pictures? (0.5)

2- What is the definition of cerebral palsy? (1)

3. What is the management of cerebral palsy?

Key::

1-

i. Right lower limb shows flexion deformity (0.25)

ii. Toe walking (0.25)

These conditions are present in upper motor neuron type of hemiplegia.

2- It is a static encephalopathy in which there is non-progressive, permanent disorder of posture & movement due to insult of the immature brain. (1)

3-

a. Multidisplinary approach (1.5)

- Pediatricition (Major role)
- Physiotherapist
- Occupational therapist
- Psychiatrist
- Orthopedic surgeon
- Nutritionists

b. To reduce spasticity (1)

- Diazepam, Baclofen, Dantrolene (0.5)
- Hearing, vision, learning and mental disorders are managed accordingly. (0.5)

c. Counseling (0.5)

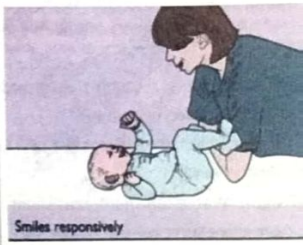
d- Follow up (0.5)

Question 40

1- What is the development age of this child? (1)

2- What are different fields development ? (1)

3- Write the one developmental milestone in each field in a 9 month old infant. (3)



Key::

1- 4 to 8 weeks (1)

2- (0.25 each)

i. Gross motor

ii. Fine motor & visions

iii. Hearing & speech

iv. Social behavior

3- (1 each for any 3 out of 4)

i. Gross motor (Site without support, reach for the toy in front, pull to stand, crawl)

ii. Fine motor & vision (Watches rolling ball at 10 feet, drops an objects and looks at fallen object, uncovers toy)

iii. Hearing & speech (localized sound above or below ear level at 3 – 6 feet, imitates adult playful sounds)

Social behavior (holds, bites & chews a biscuit, stranger anxiety, grasps bell by handle & rings in imitation, follows one step verbal commands, e.g. come here, give it to me)

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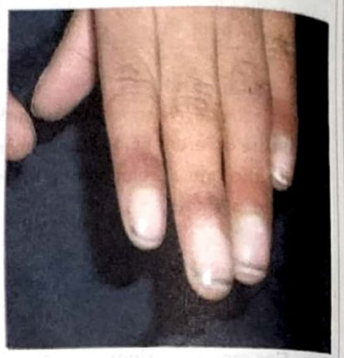
Question 41

1- What are the abnormal findings. (2)
2- What is the diagnosis? (1)
3- What are the management steps? (2)

Key::

1-
i. Cyanosis / Cyanotic spells (1)
ii. Clubbing of the fingers (1)
2- Cyanotic congenital heart disease / TOF(1)
3- Medical management (1) (0.25 each for any 4 of the 8)
- ✓ Nutritional and hygienic care
- ✓ Maintain adequate hydration
- ✓ Maintain body temperature
- ✓ Maintain hematocrit in normal range
- ✓ Iron supplements
- ✓ Prophylaxis of bacterial endocarditis
- ✓ Treat polycythemia
- ✓ Management of cyanotic spells Surgical management

i. Palliative surgery
BT shunt, Waterston shunt, pots shunt
ii. Corrective surgery



Question 42

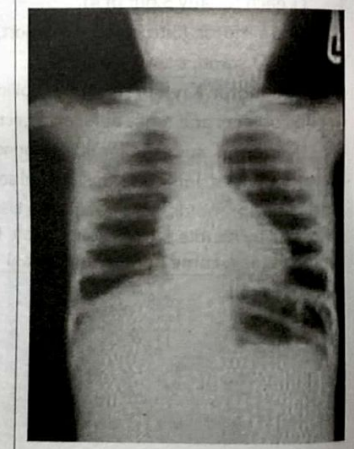
1- Write two abnormal findings in this x-ray of cyanotic infant. (1)
2- What is the diagnosis? (0.5)
3- What are the steps of management? (3.5)

Key::

1- (0.5 for any 2 out of 3)
i. Boot shape heart
ii. Oligemic lung field
iii. Narrow pedicle/base 2

Tetrology of Fallot

3. Medical management 0.25 each)
- ✓ Nutritional and hygienic care
- ✓ Maintain adequate hydration
- ✓ Maintain body temperature
- ✓ Maintain hematocrit in normal range
- ✓ Iron supplements
- ✓ Prophylaxis of bacterial endocarditis
- ✓ Treat polycythemia



- ✓ Management of cyanotic spells

Surgical Management

i. Palliative surgery: BT shunt, waterson shunt, potts shunt
ii. Corrective surgery

Closing the VSD and resecting the right ventricular outflow obstruction.

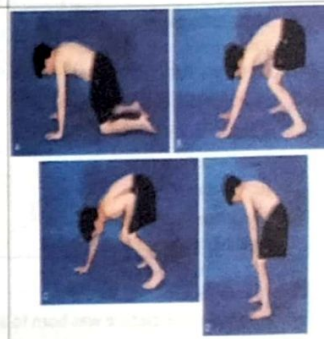
Counselling

Question 43

1: Identify the sign which is being demonstrated? (1)
2: What is the diagnosis & its inheritance? (2)
3: Enumerate 4 investigations with their yield. (2)

Key::

1-Gower's sign (1)
2- (1 each)
Duchene's Muscular dystrophy & it is x-linked recessive disorder
3- (0.5 each)
i. CPK (very high)
ii. EMG +ve (suggestive)
iii. Muscle biopsy (Diagnostic)
iv. Gene analysis (DNA) from peripheral blood (Diagnostic)

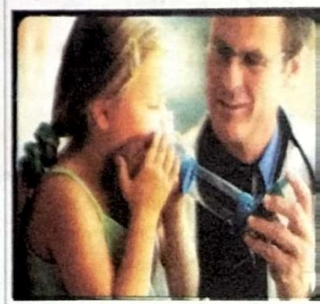


Question 44

1- Identify the device being used by the patient in this picture. (1)
2- Name the commonest disease where this device is advised. (1)
3- Write the steps of management of this disease when presenting as acute attack. (3)

KEY::

1- Spacer device with inhaler (MDI) (1)
2- Bronchial asthma (1)
3- (0.5 each for any 6)
i. O_2 inhalation
ii. Salbutamol nebulization
iii. I/V Aminophylline infusion
iv. I/V hydrocortisone
v. Adequate hydration
vi. Antibiotics if infection suspected
vii. Ventilatory support if needed



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Question 45

1. Identify the positive findings in this picture. (1)
2. Write 3 complications and 3 causes of this condition. (3)
3. What is the treatment of this condition (1)

Key::

1- Cephalhematoma (1)

2- Complications (0.5 each)

- ✓ Anemia
- ✓ Hyperbilirubinemia
- ✓ Kernicterus

Causes: (0.5 each)

i. Traumatic
ii. Coagulation disorder
iii. Platelets disorder

3- (0.5 each)

I. Conservative / observation
II. Counseling to the parents

Question 46

The newborn in the picture was born to a diabetic mother

1. Describe two positive findings in the picture. (1)
2. Enumerate 8 complications of this condition. (2)
3. Give steps of management of this case. (2)

Key::

1- i. Large for gestational age (0.5 each)
ii. Plump plethoric faces

2- (0.25 each for any 8)

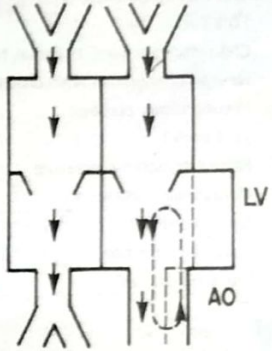
- ✓ LGA / SGA
- ✓ Birth asphyxia
- ✓ Birth trauma
- ✓ Hypoglycemia
- ✓ Hypocalcaemia / hypomagnesaemia
- ✓ Respiratory distress syndrome
- ✓ Hypertrophic Cardiomyopathy
- ✓ Hyperbilirubinemia
- ✓ Polycythemia
- ✓ Congenital malformations

3- (0.5 each)

- ✓ Careful screening for any evidence of birth asphyxia and birth trauma
- ✓ Careful screening for any congenital malformation
- ✓ Prevention and treatment of hypoglycemia and hypocalcaemia
- ✓ Prevention and treatment of any other complication

Question 47

Q 1 What is the diagnosis of this condition(1)
Q 2 Name the commonest acquired cause of this condition in Pediatrics (1)
Q 3 What clinical findings will be present in this case. (3)



Key::

1- Aortic regurgitation (1)

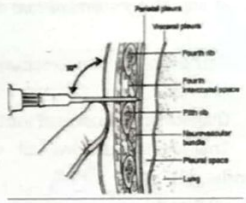
2- Rheumatic fever / Rheumatic valvular heart disease

3. 0.5 each

i. High volume bounding pulses
ii. Collapsing / water hammer pulse
iii. Bulging of the precardium
iv. Lateral & downward Shifting of the apex beat
v. Muffled second heart sound
vi. Early diastolic murmur at the aortic area

Question 48

1- Identify the procedure which is being shown in the picture? (1)
2- What are the indications of this procedure? (2)
3- What are contraindications of this procedure? (2)



Key::

1- Thoracentesis (Pleural tap) (1)

2- (1 each)

(i) Diagnostic evaluation of pleural effusion.
(ii) Therapeutic drainage of pleural effusion in patients with respiratory compromise.

3- (1 each for any 2)

(i) Local skin infection (e.g. Herpes zoster)
(ii) Bleeding diathesis, anticoagulant therapy
(iii) Mechanical ventilation

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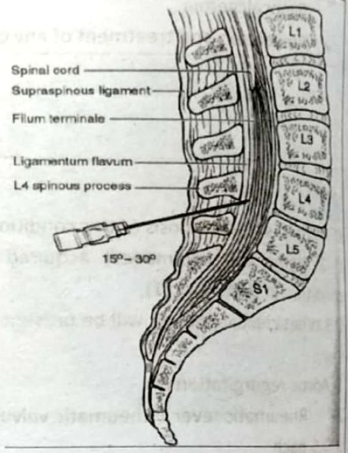
Question 49

1- Identify the instrument being shown in the diagram. (1)
2- What are the indications of its use. (1.5)
3- What are the contraindications of its use. (2.5)

Key::

1- Lumber Puncture Needle (1)
2- (0.5 each)
(i) CNS infections (viral, bacterial, tuberculus)
(ii) Neuro degenerative brain disease
(iii) Pseudo tumor cereberi
3- (0.5 each)
- ✓ Raised intracranial pressure
- ✓ Intracranial mass lesion
- ✓ Spinal cord mass
- ✓ Local skin infection
- ✓ Bleeding diathesis

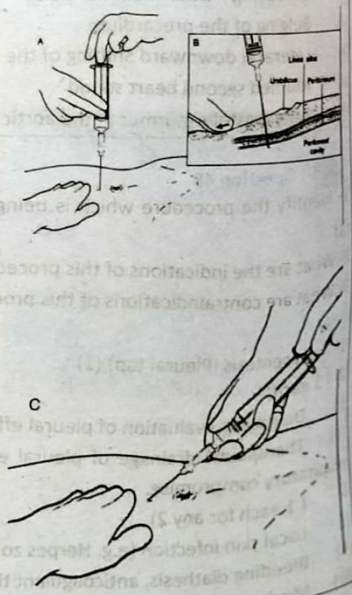


Question 50

1- Identify the procedure which is being demonstrated in this picture. (1)
2- What are the indications of this procedure? (2)
3. What are the contraindications of this procedure? (2)

Key::

1- Peritoneal Tap (Paracentesis) (1)
2- (1 each)
(i) Diagnostic evaluation of ascitic fluid(1)
(ii) Therapeutic removal of ascitic fluid in respiratory comprise. (1)
3- (0.5 each)
(i) Infection of the abdominal wall
(ii) Hemodynamically unstable patient
(iii) Intestinal perforation
Bleeding diathesis



Question 51

1- Identify the procedure which is being shown in the above picture? (1)
2- Enumerate 3 basic parameters in evaluation during neonatal resuscitation. (1.5)
3- What is APGAR score? (2.5)

Key::

1- Bag and Mask ventilation (1)
2- (0.5 each)
i. Respiration
ii. Heart rate
iii. Colour
3- (0.5 for each correct horizontal line)

	0	1	2
A: Appearance (colour)	Blue, pale	Body pink, extremities blue	Fully pink
P: Pulse (heart rate)	Absent	Below 100	Over 100/min
G: Grimace (response	No response	Facial grimace	Cry
to stimulation)			
A: activity (muscle tone)	Flaccid	Some flexion	Normal with movements
R: Respiration	Absent	Gasping	Regular

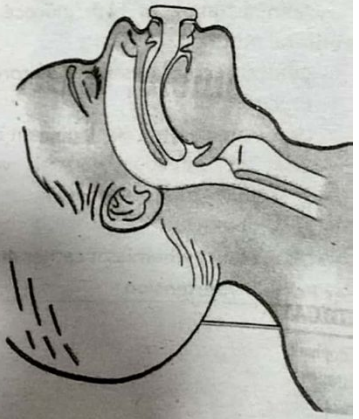
Question 52

1- Identify the instrument being used in this picture. (1)
2- What are the indications of uses of this instrument? (1)
3- What complications may result from use of this instrument? (3)

Key::

1- Oropharyngeal airway (1)
2- Maintenance of airway in unconscious patient (1)
3- (1 each for any 3)
- ✓ If large airway used it may traumatize the laryngeal structure
- ✓ If large airway used it may induce vomiting and can lead to aspiration.
- ✓ If airway insert improperly it may push tongue posteriorly and can lead to obstruction.

Introduction of infection



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Question 53

1- What step of resuscitation is being shown in the above diagram? (1)
2- What is the indication for doing this step? (2)
3- What complications may result if this step done vigorously? (2)

Key::

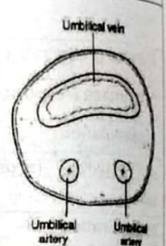
1- Cardiac compression along with bag & mask ventilation. (1)
2- When heart rate is below 60/min inspite of bag & mask ventilation, then chest compression is started. (2)
3- (0.5 each)
i. Chest contusions and abrasions
ii. Rib fractures
iii. Epicardial hematoma
iv. Pulmonary hemorrhage

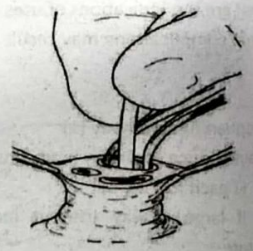
Question 54

1- Identify the procedure being shown in the picture? (1)
2- What are the 2 indications of this procedure? (2)
3- What are the complications of this procedure? (2)

Key::

1- Umbilical vein cannulation (1)
2 (1 each for any 2 out of 4)
i. For exchange transfusion
ii. Emergency vascular access for fluid & medication when I/V cannot be maintained.
iii. Administration of high glucose concentration and total parenteral nutrition.
iv. Central venous pressure monitoring
3- (0.5 each for any 4)
i. Hemorrhage from displacement of cather
ii. Risk of infection (portal vein thrommbophnebitis, ascending cholangitis, septicemia).
iii. Air embolism
iv. Cardiac arrhythemias if cather mal positioned in heart
Later Portal hypertension





Question 55

1- What examination is being shown in this picture? (1)
2- Enumerate 6 common causes of hypertension in children. (3)
3- Enumerate 4 complications of hypertension in children. (1)

Key:

1- Blood pressure measurement (1) 2- (0.5 each for any 6 out of 7)
✓ Acute glumerolonephritis
✓ Chronic glumerolonephritis
✓ Vesicourteral reflux nephropathy
✓ Renal artery stenosis
✓ Coarctation of aorta
✓ Cushing's syndrome
✓ Congenital adrenal hyperplasia
3- (0.25 each)
✓ Hypertensive encephalopathy
✓ Hypertensive cardiac failure
✓ Cerebro vascular accident
Hypertensive retinopathy

Question 56

A 10 hours old premature baby born at 30 weeks of gestation is brought to emergency room. His radiograph is as under

1. Give 2 positive findings in this radiograph & what is the diagnosis. (2)
2. What other investigations are needed to reach final diagnosis. (2)
3. What specific treatment this condition needs. (1)

Key::

1. (i) Ground glass appearance (0.5)
(ii) Cardiac shadow not distinguishable (0.5)
(iii) Idiopathic respiratory distress syndrome (IRDS) (1)
2- (i) ABGs (1)
(ii) Sepsis screen (CBC, CRP, Blood culture) (1)
3- (i) Ventilatory support (0.5) (ii) surfactant therapy (0.5)

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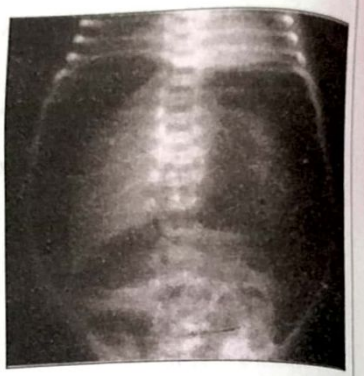
Question 57

A 7 days old premature baby admitted in NICU taking formula feeding became lethargic for last 2 days, passed thrice mucoid stool along with blood yesterday. Now for last 3 hours, having abdominal distension. His X-ray abdomen was advised which is as under

1- Give positive finding in this radiograph. (1)
2- Name 6 risk factors of this condition. (1.5)
3- Write steps of management of this condition. (2.5)



Key::

1- Free air in the peritoneal cavity (Pneumoperitoneun). (1)
2- (0.25 for each)
- ✓ Prematurity
- ✓ Asphyxia
- ✓ Enteral feeding
- ✓ Hyperosmolar formula feeding v Polycythemia
- ✓ Exchange transfusion

3.
- ✓ Maintain A,B,C
- ✓ NPO
- ✓ Gastric drainage by passing NG tube
- ✓ maintenance of fluids & electrolytes
- ✓ Systemic antibiotics (ampicillin + Gentamycin + Metronidazole)
- ✓ Monitor IOP
- ✓ Monitor abdominal girth
- ✓ Surgical intervention

Unit 7

SECRETS OF ENT

Question 1

Carefully examine the given X ray and answer the questions.
a. What is the view of this X ray?
b. Explain X ray.

Answer:
a. Waters' view with open mouth
b. Haziness of left maxillary sinus due to mucosal hypertrophy (arrow). Other sinuses appear normal

Question 2

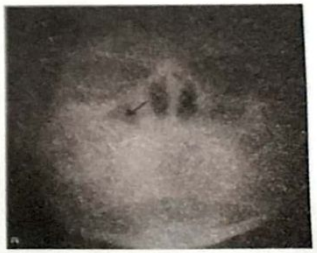
Carefully examine the given X ray and answer the questions.
a. What is the view of this X ray?
b. Explain X ray.

Answer:
a. Waters' view
b. Opacity in right maxillary sinus due to sinusitis (arrow)

Question 3

Carefully examine the given X ray and **Answer** the questions.
a. What is the view of this X ray?
b. Explain X ray.

Answer:
a. Waters's view
b. Waters's view showing a globular cyst in the right (arrow) and mucosal hypertrophy in the left maxillary sinus.



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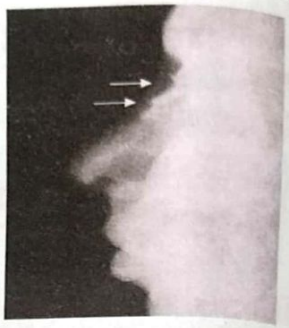
Question 4

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view of nasal bones
b. Lateral view of nasal bones showing fracture



Question 5

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Waters's view
b. Waters' view showing carcinoma
Right maxillary sinus i. soft tissue expansion
ii. Bony destruction of walls of maxillary sinus

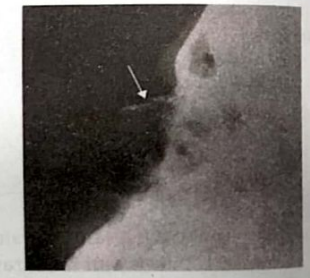
Question 6

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view-nasal bones
Fracture of nasal bone (arrow)



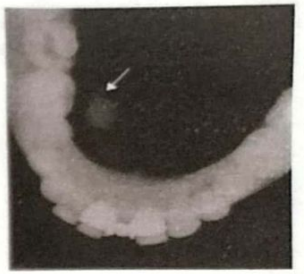
Question 7

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Occlusal view
b. Occlusal view showing a stone in right Submandibular duct



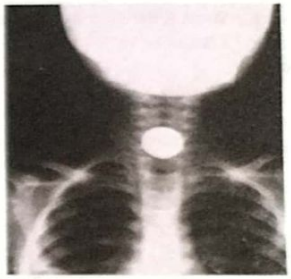
Question 8

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. PA view
b. A radio-opaque foreign body (coin) in The esophagus at the level of thoracic Inlet



Question 9

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view neck
b. Lateral view neck showing a foreign body (coin) in esophagus. Note the end-on position of coin in this position.

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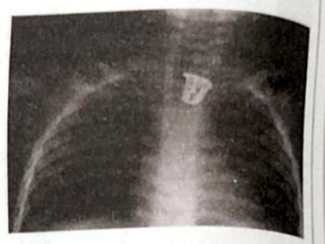
Question 10

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. PA-view
b. Neck and chest showing a ring at the level Of thoracic inlet



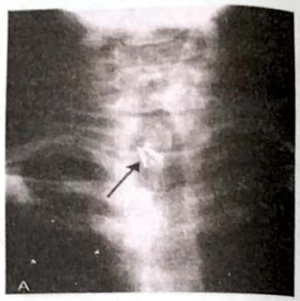
Question 11

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. PA-view
b. Neck and chest with denture at the level of thoracic inlet. Denture is radiolucent but two metallic hooks are visible (arrow).



Question 12

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view
b. Neck of the same patient in above Question showing metallic hooks at Thoracic inlet (arrow)

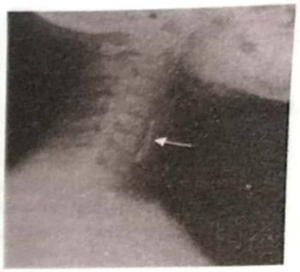
Question 13

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view
b. Open safety pin in the esophagus Note its point is directed downwards



Question 14

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. X ray lateral view neck
b. X ray lateral view neck showing a Chicken bone in the esophagus Opposite C7 and C8 (arrows)

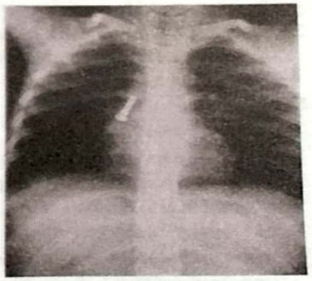
Question 15

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. PA view chest
b. A radio-opaque foreign body (nail) In the right bronchus



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Question 16

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view neck
b. Soft tissue lateral view neck showing a Fruit seed (chiku) in the subglottic region of larynx (arrow). Note: the patient needed tracheostomy (black arrow) to relieve obstruction.

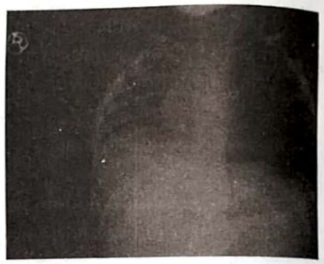
Question 17

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. PA chest
b. PA chest in a child with a radiolucent foreign body (a peanut) in right bronchus. Note: i. collapse of right lung and shift of mediastinum to the same side ii. Raised dome of diaphragm on the right. iii. Emphysema left lung



Question 18

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view neck
b. Soft tissue lateral view neck showing retropharyngeal and retro-esophageal abscess due to a fish bone in a 25 year old female . Note: i. increased prevertebral soft tissue shadow (maximumagainst C7). ii. Compression Of trachea compromising the airway. iii. straightening of cervical spine. iv. Vertebral bodies and intervertebral spaces are normal.

Question 19

Carefully examine the given X ray and **Answer** the question.

a. Explain X ray.

Answer:

a. Hypodermic injection needle in the trachea in an adult. Sudden gasp due to a pat on the back from an unnoticed friend when he was busy picking his teeth.

Question 20

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view Neck
b. Radiograph (lateral view neck) showing retropharyngeal abscess. Note increase in width of prevertebral soft tissues opposite C6 and also gas shadow due to gas-producing organisms. To diagnose retropharyngeal abscess, the prevertebral soft tissue shadow should exceed width of body of C2 (or should be more than 7 mm) in both children and adults opposite C2. Opposite C6, the soft tissue shadow should exceed 14 mm in children less than 15 years and 22 mm in adults.

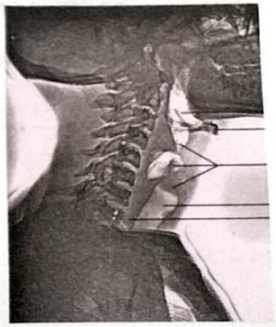
Question 21

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Xeroradiograph (lateral view neck)
b. Note laryngeal stenosis involving Supraglottic, glottis and subglottic Regions.



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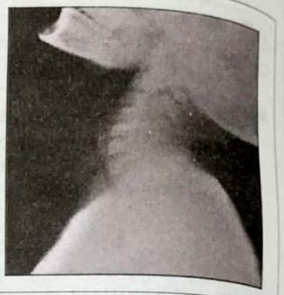
Question 22

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view of neck
b. Soft tissue radiograph (lateral neck) showing tracheal compression due to thyroid mass.



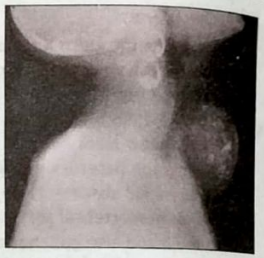
Question 23

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view of neck
b. Lateral view neck showing calcification In the thyroid gland.



Question 24

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Lateral view-nasopharynx
b. Soft tissue lateral view-nasopharynx. Note a large adenoid mass almost Completely obstructing the Nasopharyngeal airway (arrowheads)

Question 25

Carefully examine the given X ray and **Answer** the question.

a. Explain X ray.

Answer:

a. Barium swallow in a patient with dysphagia. Note irregular narrowing Of lower esophagus due to carcinoma.

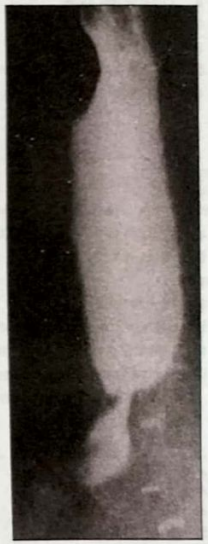
Question 26

Carefully examine the given X ray and **Answer** the question.

a. Explain X ray.

Answer:

a. Cardiac achalasia (megaesophagus). There is a failure of lower esophagus Sphincter to relax with dilatation of esophagus due to stasis of food. Achalasia is due to degeneration of Ganglion cells of Auerbach's plexus.



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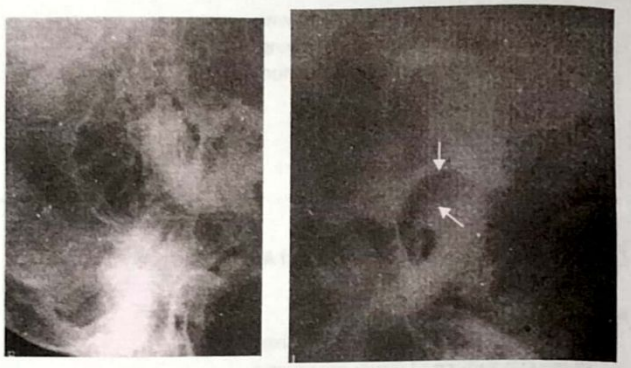
Question 27

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

a. Law's view of mastoid
A. Note normal structures And pneumatization on the right.
B. On the left side mastoid is sclerotic with destruction (arrows) of the "key area" due to cholesteatoma.



Question 28

Carefully examine the given X ray and **Answer** the questions.

a. What is the view of this X ray?
b. Explain X ray.

Answer:

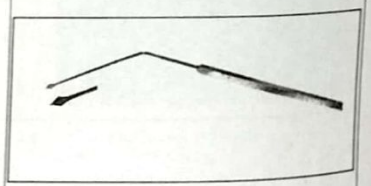
a. Transorbital view
b. Both petrous pyramids are projected through the orbits. Internal auditory meatus and labyrinths are seen on both sides. Internal auditory canals of both sides are normal in shape and dimensions (arrows).

Question 29

a. Identify the instrument.
b. Write Uses?

Answer:

a. Myringotome
b. Used for myringotomy

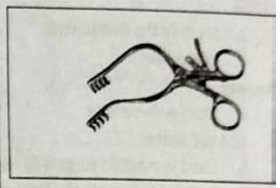


Question 30

a. Identify the instrument.
b. Write Uses?

Answer:

a. Mollison's mastoid retractor
b. Used in mastoidectomy to retract soft tissues after incision and elevation of flaps. It is self retaining and haemostatic.

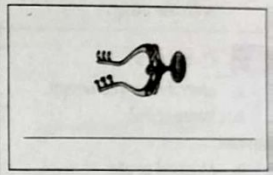


Question 31

a. Identify the instrument.
b. Write Uses?

Answer:

a. Jansen's self-retaining mastoid retractor
b. Used in mastoidectomy Similar to Mollison's retractor.



Question 32

a. Identify the instrument.
b. Write Uses?

Answer:

a. Lemper's endaural retractor
b. Used for endaural approach to ear surgery. It has two lateral blades which retract the flaps and a third central blade with holes. The central blade retracts the temporalis muscle. The central blade can be fixed to the body of the retractor by its hole.

Question 33

a. Identify the instrument.
b. Write Uses?

Answer:

a. Lempert's endaural speculum
b. It is like Vienna model nasal speculum but curved. It is used to spread open the meatus when giving local injection or making an endaural incision.

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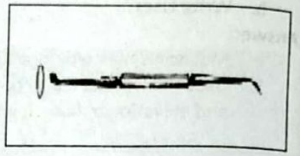
Question 34

a. Identify the instrument.
b. Write Uses?

Answer:

a. MacEwn's curette and cell seeker
b. Used in mastoid surgery to explore the air cells with one end and to curette the intervening septa and granulations with the other.

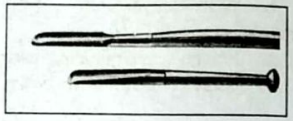


Question 35

a. Identify the instrument.
b. Write Uses?

Answer:

a. Mastoid gouge
b. Used to remove bone in mastoid surgery

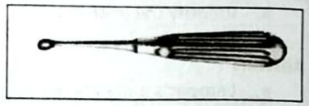


Question 36

a. Identify the instrument.
b. Write Uses?

Answer:

a. Lempert's curette (scoop)
b. Used for removal of bony septa and granulations in mastoid surgery

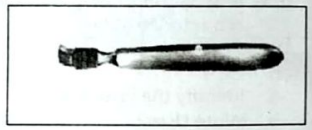


Question 37

a. Identify the instrument.
b. Write Uses?

Answer:

a. Farabeuf periosteal elevator
b. Used for elevation of periosteum from the mastoid cortex in mastoidectomy

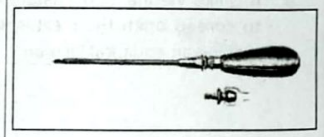


Question 38

a. Identify the instrument.
b. Write Uses?

Answer:

a. Lichtwitz trocar and cannula
b. Used for proof puncture (antral lavage). Puncture is done in the inferior meatus as this site is easily accessible and safe.



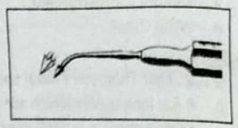
Question 39

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tilley's harpoon
b. Used for intranasal antrostomy in the inferior meatus. Its advantage lies in the removal of the bony chips when the instrument is withdrawn so that they don't fall in the sinus cavity.

It is rarely used these days.

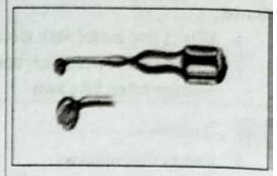


Question 40

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tilley's antral burr
b. Used to enlarge and smoothen the hole Made by harpoon in intranasal inferior Meatal antrostomy. No longer used now.

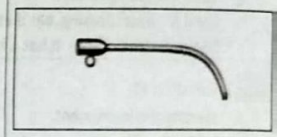


Question 41

a. Identify the instrument.
b. Write Uses?

Answer:

a. Rose's sinus douching cannula
b. Used in irrigation of maxillary sinus, which already has a nasoantral window due to intranasal antrostomy or Caldwell-luc operation. Direction of the tip is indicated by the hook outside.

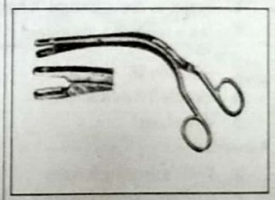


Question 42

a. Identify the instrument.
b. Write Uses?

Answer:

a. Luc's forceps
b. Used in cald-well operation (to remove mucosa), submucosal resection (SMR) operation (to remove bone Or cartilage), polypectomy (to grasp and avulse polyp) And to take biopsy from the nose or throat.

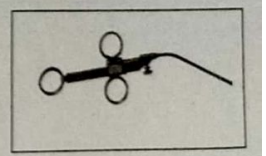


Question 43

a. Identify the instrument.
b. Write Uses?

Answer:

a. Nasal snare (Krause's)
b. Used for removal of nasal polypi. Polyp is engaged in the wire loop and avulsed. Its use has greatly declined now. Wire used in this snare is 30 SWG.

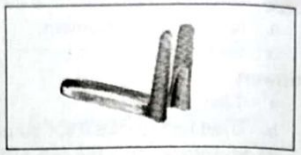


Question 44

a. Identify the instrument.
b. Write Uses?

Answer:

a. St. Clair Thomson's nasal speculum
b. It has long blades which are concave from inside. Used in nasal surgery, e.g. SMR operation or septoplasty.

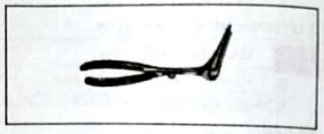


Question 45

a. Identify the instrument.
b. Write Uses?

Answer:

a. Killian's long bladed nasal speculum
b. Used in SMR or septoplasty operation to keep mucoperiosteal flaps away.

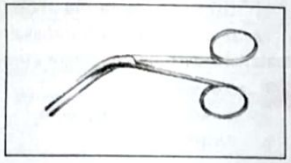


Question 46

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tilley's dressing forceps
b. Used for nasal packing, ear dressing, removal of foreign bodies from the nose. It has a box joint.

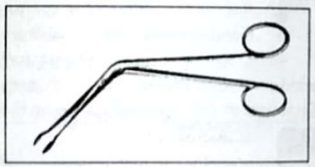


Question 47

a. Identify the instrument.
b. Write Uses?

Answer:

a. Hartmann's dressing forceps
b. Similar to above forceps. It has a screw joint. The jaw is serrated and grooved.

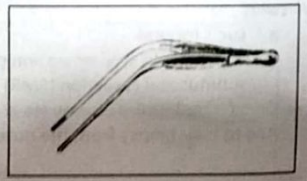


Question 48

a. Identify the instrument.
b. Write Uses?

Answer:

a. Wilde's dressing forceps
b. Used for packing the nasal cavity or ear canal. It acts on spring action.

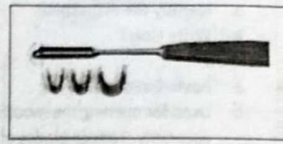


Question 49

a. Identify the instrument.
b. Write Uses?

Answer:

a. Ballenger swivel knife
b. Used in removal of septal cartilage in SMR operation. The blade of knife revolves automatically and changes Direction when cutting the cartilage anteroposteriorly downwards and posteroanteriorly. Different sizes of blades are also shown. Can be used to harvest septal cartilage as a graft for reconstruction.

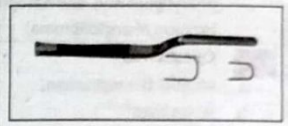


Question 50

a. Identify the instrument.
b. Write Uses?

Answer:

a. Killian's nasal gouge (bayonet-shaped)
b. Used for removal of septal spurs or bony crests and ridges in SMR operation.

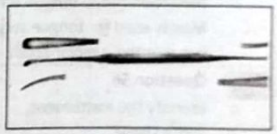


Question 51

a. Identify the instrument.
b. Write Uses?

Answer:

a. Freer's double-ended elevator
b. Used for elevation of mucoperichondrium or periosteum In SMR or septoplasty operation

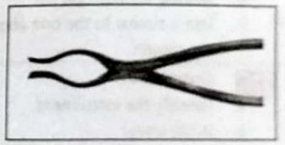


Question 52

a. Identify the instrument.
b. Write Uses?

Answer:

a. Walsham's forceps
b. Used for disimpacting and reducing fractures of nasal bone

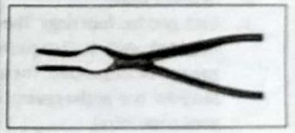


Question 53

a. Identify the instrument.
b. Write Uses?

Answer:

a. Asch's septum forceps
b. Used for reducing fractures of nasal septum
c.



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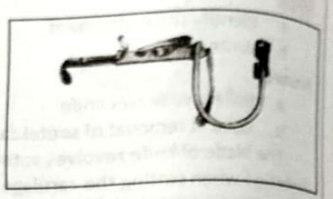
Question 54

a. Identify the instrument.
b. Write Uses?

Answer:

a. Boyle-Davis mouth gag
b. Used for opening the mouth and retracting the tongue anteriorly. Tongue blades of various sizes can be interchanged according to the age of the patient. It is used for various operations on the oral cavity (palate surgery), oropharynx (tonsillectomy, surgery of soft palate, pharyngoplasty), and nasopharynx (adenoidectomy, excision of angiofibroma).

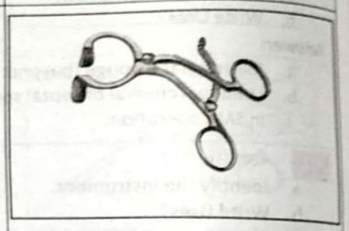


Question 55

a. Identify the instrument.
b. Write Uses?

Answer:

a. Doyen's mouth gag
b. Used to keep the mouth open for intraoral surgery when retraction of the tongue is not required or desireable. Mostly used for tongue surgery. It is applied on one side of the mouth on molar teeth.



Question 56

a. Identify the instrument.
b. Write Uses?

Answer:

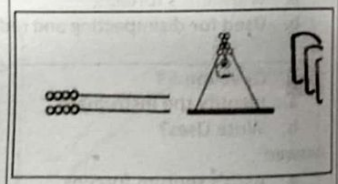
a. Jenning's mouth gag
b. Use is similar to the one above. It is applied in the centre of the mouth.

Question 57

a. Identify the instrument.
b. Write Uses?

Answer:

a. Draffin's bipod
b. Each pod has four rings. They can be assembled to vary the height at which the tongue blade of the Boyle-Davis mouth gag can be suspended. The lower end of each pod can be placed in one of the several depressions in Magauran's plate (vide infra).

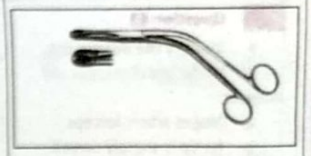


Question 58

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tonsil holding forceps (Denis Browne's)
b. Used for holding the tonsil during tonsillectomy by dissection method.

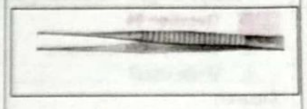


Question 59

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tonsil diseection forceps with teeth (Waugh's)
b. For incision in mucous membrane and dissection of tonsil

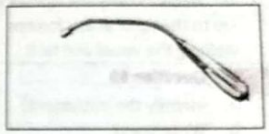


Question 60

a. Identify the instrument.
b. Write Uses?

Answer:

a. Yankauer suction tube
b. Used for suction in tonsillectomy and other oral or oropharyngeal operations

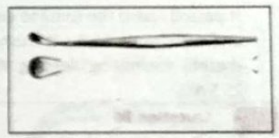


Question 61

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tonsil dissector and anterior pillar retractor
b. One end is used to dissect the tonsil and the other to retract the the anterior pillar to inspect the fossa for any bleeding point.

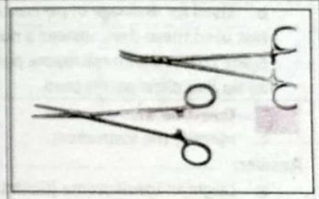


Question 62

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tonsil artery forceps (straight and curved)
b. Straight forceps is used to catch the bleeding point and curved one is used as replacement forceps before tying with a ligature.



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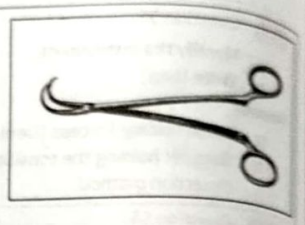
Question 63

a. Identify the instrument.
b. Write Uses?

Answer:

a. Negus artery forceps
b. Its tip is sharply curved.
The forceps is used as replacement
Forceps to ligate the bleeding point.

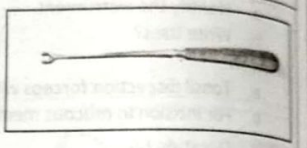


Question 64

a. Identify the instrument.
b. Write Uses?

Answer:

a. Negus knot tier
b. Helps to carry the ligature knot
Up to the tip of artery forceps
Holding the vessel and tie it.

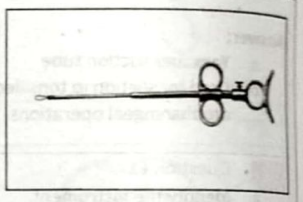


Question 65

a. Identify the instrument.
b. Write Uses?

Answer:

a. Eves' Tonsil snare
b. Used for tonsillectomy. After the tonsil has been dissected till its lower pole, snare is passed round the tonsil to engage the pedicle and then firmly closed. It crushes and cuts the pedicle thereby minimizing bleeding. Wire used in snare is number 25 SWG.

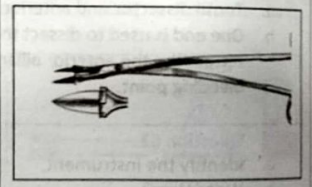


Question 66

a. Identify the instrument.
b. Write Uses?

Answer:

a. Peritonsillar abscess forceps
b. Used for drainage of peritonsillar abscess. Not used these days; instead a number 11 Blade covered with micropore plaster except its tip and distal part is used.

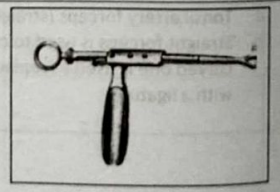


Question 67

a. Identify the instrument.

Answer:

a. Leighten tonsillotome (Guillotine)

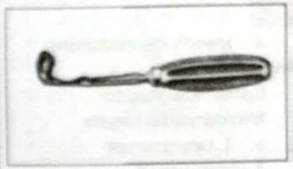


Question 68

a. Identify the instrument.
b. Write Uses?

Answer:

a. St. Clair Thompson's adenoid Curette with guard
b. Used in adenoidectomy. Curette shaves off the adenoid mass while the guard holds the tissue and prevents its slipping.



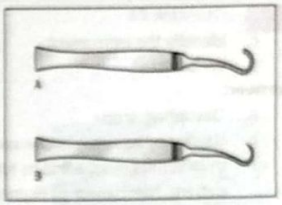
Question 69

a. Identify the instrument.
b. Write Uses?

Answer:

a. A. Blunt tracheal hook
B.Sharp tracheal hook

b. Blunt tracheal hook (A) is used to retract thyroid isthmus upwards or downwards to expose the trachea.
Sharp tracheal hook (B) is applied to lower border of cricoid cartilage to stabilize the trachea and prevents its movements during respiration when making incision In the tracheal wall.

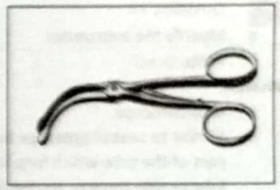


Question 70

a. Identify the instrument.
b. Write Uses?

Answer:

a. Tracheal dilator
b. Used to keep open the tracheal edges After incision in the trachea so that tracheostomy Tube can be easily inserted. A curved artery forceps Can be easily used in place of a tracheal dilator.

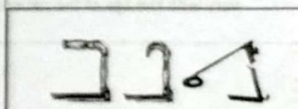


Question 71

a. Identify the instrument.
b. Write Uses?

Answer:

a. Laryngoscope
b. Used for direct laryngoscopy (diagnostic or therapeutic). It has a single or a twin light carrier which can be connected to a cold-light source through a flexible cable. Older models have a small electric bulb which works on batteries or a transformer. There are several models of laryngoscope. The size of laryngoscope used will vary with the age of the patient.



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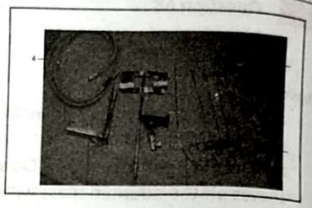
Question 72

a. Identify the instrument.

Answer:

Instruments used for Microlaryngeal surgery

a. 1. Laryngoscope
2. Chest support
3. Suction tip
4. Fibreoptic cord
5. Various types of microlaryngeal instruments
6. Specimen bottle

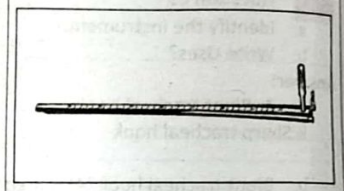


Question 73

c. Identify the instrument.
d. Write Uses?

Answer:

a. Oesophagoscope
b. Used for diagnostic or therapeutic oesophagoscopy. Length of oesophagoscope and its lumen vary with the age of the patient. Mechanism of illumination is similar to that of laryngoscope. Handle, at the proximal end of oesophagoscope, indicates the direction of the bevel at the distal end. Illustrated below is Negus oesophagoscope with twin proximal lighting.

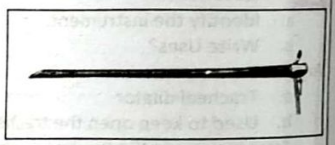


Question 74

a. Identify the instrument.
b. Write Uses?

Answer:

a. Bronchoscope
b. Similar to oesophagoscope but has openings at the distal part of the tube which help in ventilation of contralateral lung or side bronchi. Its distal tip is also beveled to facilitate its passage between the cords. Size of bronchoscope will vary with the age of the patient.

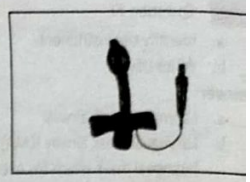


Question 75

a. Identify the instrument.
b. Write Uses?

Answer:

a. Cuffed tracheostomy tube
b. When cuff is inflated, it presents aspiration of pharyngeal secretions into the trachea. It can also prevent air-leak. It is used when there is danger of aspiration of pharyngeal secretions as in unconscious patient or when patient is put on a respirator. Cuff should be deflated every 2 h for 5 min to prevent damage to trachea and cartilage necrosis. Nowadays tubes with two cuffs are available and inflation of the cuff can be alternated to avoid cuff pressure at one site in trachea.



Question 76

a. Identify the instrument.
b. Write Uses?

Answer:

a. Cuffed suction-aid Tracheostomy tube
b. It is like an ordinary cuffed tube but also has a suction tube which reaches above the cuff. It helps to suck out pharyngeal secretion collected above the cuff. Suction should always be done before deflating the cuff so that accumulated pharyngeal secretions do not get aspirated into the trachea.

SECRETS OF PMDC-III

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Question 77

a. Identify the instrument.
b. Write Uses?

Answer:

a. Laryngeal mask airway
b. Laryngeal mask airway (LMA) is a device with a tube and a laryngeal mask which fits over the supraglottic region. Size of mask is selected according to the weight of the patient. The cuff of mask is first deflated and positioned over the larynx and later inflated. It is used where face mask is ineffective and intubation of the larynx difficult. Other advantages of LMA include:
. To intubate the patient with endotracheal tube (less than 6mm inner diameter) directly or to first pass a stylet and then rail-road endotracheal tube.
. To pass flexible bronchoscope for fibreoptic assessment of airway and then pass the stylet.

LMA is not as effective as endotracheal tube to prevent aspiration of gastric secretions. Its use is contraindicated in obstruction in the area of glottis and subglottis and cannot be used in patients with trismus.

Question 78

a. Write 5 functions of tracheostomy?
b. Write 3 main indications of tracheostomy?
c. Write type of tracheostomy?

Answer:

a. i. Alternative pathway for breathing
ii.Improves alveolar ventilation
iii. Protects the airways
iv.Permits removal of tracheobronchial secretions
v.Intermittent positive pressure respiration (IPPR)
vi.To administer anaesthesia
b. i. Respiratory obstruction
ii. Retained secretions
iii. Respiratory insufficiency
c. i. Emergency tracheostomy
ii. Elective or tranquil tracheostomy
iii. Permanent tracheostomy
iv. Percutaneous dilatational tracheostomy
v. Mini tracheostomy (Cricothyroidotomy)

Write Common Indications of tracheostomy in infants and children

Ans:

Infants below 1 yr (mostly congenital lesions)
i. Subglottic haemangioma
ii. Subglottic stenosis
iii. Laryngeal cyst
iv. Glottic web
v. Bilateral Vocal cord paralysis

Children (mostly inflammatory or traumatic lesions)
i. Acute laryngo-tracheo-bronchitis
ii. Epiglottitis
iii. Diphtheria
iv. Laryngeal oedema (chemical/thermal injury)
v. External laryngeal trauma
vi. Prolonged intubation

Juvenile laryngeal papillomatosis

Question 79

Write Complications of Tracheostomy?

Answer:

1. Immediate (at the time of operation)
a. Haemorrhage
b. Apnoea
c. Pneumothorax due to injury to apical pleura
d. Injury to recurrent laryngeal nerves
e. Aspiration of blood
f. Injury to oesophagus
2. Intermediate (During first few hours or days)
a. Bleeding, reactionary or secondary
b. Displacement of tube
c. Blocking of tube
d. Subcutaneous emphysema
e. Tracheitis and tracheobronchitis with crusting in trachea
f. Atelectasia and lung abscess
g. Local wound infection and granulations
3. Late (with prolonged use of tube for weeks and months)
a. Haemorrhage due to erosion of major vessel
b. Laryngeal stenosis due to perichondritis of cricoids cartilage
c. Tracheal stenosis due to tracheal ulceration and infection
d. Trachea-oesophageal fistula, due to prolonged use of cuffed tube or erosion of trachea by the tip of tracheostomy
e. Problems of decannulation. Seen commonly in infants and children.
f. Persistent tracheocutaneous fistula
g. Problems of tracheostomy scar. Keloid or unsightly scar

Corrosion of tracheostomy tube and aspiration of its fragments into the tracheobronchial tree

Question 80

Write Indications of Tonsillectomy?

Answer:

A. Absolute Indications
h. Recurrent infections of throat.
This is the most common indication. Recurrent infections are further defined as:
a. Seven or more episodes in 1 year or
b. Five episodes per year for 2 years or
c. Three episodes per year for 3 years or
d. Two weeks or more of lost school or work in 1 year

ii. Peritonsillar abscess.
In children, tonsillectomy is done 4-6 weeks after abscess has been treated. In adults, second attack of peritonsillar abscess forms the absolute indication.
iii. Tonsillitis.
It causes febrile seizures
iv. Hypertrophy of tonsils.
It causes:
a. Airway obstruction (sleep apnea)
b. Difficulty in deglutition and
c. Interference with speech
v. Suspicion of malignancy.
A unilaterally enlarged tonsil may be a lymphoma in children and an epidermoid carcinoma in adults. An excisional biopsy is done.

B. Relative:
1. Diphtheria carriers who don't respond to antibiotics
2. Streptococcal carriers who may be the source of infection to others
3. Chronic tonsillitis with bad taste or halitosis which is unresponsive to medical treatment
4. Recurrent streptococcal tonsillitis in a patient with valvular heart disease

C. As a part of another Operation:
1. Palatopharyngeal which is done for sleep apnea syndrome
2. Glossopharyngeal neurectomy. Tonsil is removed first and then IX nerve is severed in the bed of tonsil
3. Removal of styloid process

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Question 81

Write Contraindications of Tonsillectomy?

1. Haemoglobin level less than 10%
2. Presence of acute infection in upper respiratory tract, even acute tonsillitis. Bleeding is more in the presence of acute infection.
3. Children under 3 years of age. They are poor surgical risks
4. Overt or submucous cleft palate
5. Bleeding disorders e.g leukemia, purpura, aplstic anemia or haemophilia
6. At the time of epidemic of polio
7. Uncontrolled systemic disease, e.g diabetes, cardiac disease, hypertension or asthma

Tonsillectomy is avoided during the period of menses

Question 82

4 year old girl was brought in ENT OPD by the mother telling that she saw some white shinning thing in the left ear. The girl had no complaints. On examination there was a white plastic bead lying close to the tympanic membrane. She otherwise is a very cooperative child.

a. What is your diagnosis?
b. How will you remove this?
c. What are two kinds of these?
d. Which type this belongs to?
e. If this type is not treated immediately what will happen?

Answer:

a. Foreign body in ear
b. As the child is cooperative, it can be removed by syringing.
c. Organic and inorganic
d. Inorganic

Nothing serious will happen

Unit 8

SECRETS OF MEDICINE

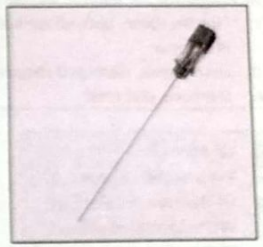
HIGH YIELD

Question 1

a. Identify the object.
b. Write indications of its use?
c. Write contraindications of its use?
d. Write complications?

Answer:

a. Lumbar Puncture Needle
b. Spinal anesthesia, diagnostic in Meningitis, diagnostic in subarachnoid haemorrhage, therapeutic in intra thecal administration of drugs
c. Bleeding disorder , meningococcal sepsis, increased ICP or Papilledema, intracranial mass lesion on CT scan, Local sepsis
d. Cerebellar herniation, headache, hypotension

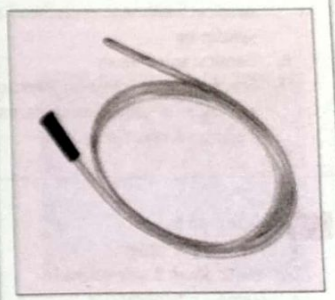


Question 2

a. Write name of this instrument?
b. Write indications of its use?
c. Write complications of its use?
d. What are the contraindications?

Answer:

a. Nasogastric tube
b. Stomach wash, feeding the unconscious patients, decompression of stomach contents, therapeutic gastric lavage in poisoning
c. Aspiration pneumonia due to marked reflux of gastric contents, local infections, wrong placement, stricture, bleeding, trauma to nose, pharynx , esophagus and stomach, uncontrolled dietary intake due to non-selective intake of food and only liquids to be given
d. Corrosive poisoning



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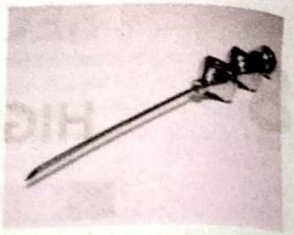
Question 3

a. Write name of the instrument?
b. Write indications?
c. Name the sites of biopsy.
d. Write contraindications?
e. What site is commonly selected for the test?

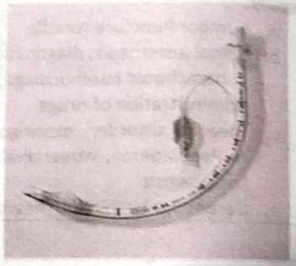


Answer:

a. Bone marrow aspiration needle
b. i. Diagnostic for leukemia, anemia, pancytopenia
ii. To see the morphology of bone marrow and various cell lines
iii. Secondary malignant lesions
iv. Prognostic for aplastic anemia and agranulocytosis
c. Lumbar spine, body of sternum, tibia upper end. Posterior iliac fossa
d. Local sepsis, deranged coagulation profile
e. Sternum, iliac crest

Question 4

a. What is this instrument?
b. Write down indications?
c. Write contraindications?
d. Write down 2 complications?



Answer:

a. Endotracheal tube
b. CPR, mechanical ventilation in bed bound, anesthesia, acute respiratory arrest, status asthmaticus after failure of medical treatment, myasthenia gravis, Guillian Barre syndrome
c. Cervical spine injury
d. Trauma during insertion, infections, injury to vocal cords, aspiration of gastric contents, tracheal stenosis, wrong placement in esophagus

Question 5

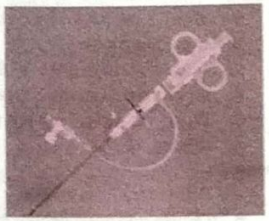
a. Identify the object?
b. Write down 3 indications?
c. Name 2 complications.
d. Write 1 contraindication?

Answer:

a. Renal biopsy needle
b. Nephritic syndrome, Nephritic syndrome, Renal disease in connective tissue disorders, Unexplained renal failure
c. Local infection, bleeding, loin pain
d. Hypertension

Question 6

a. Identify the object?
b. Write down 5 indications?
c. Name 2 complications.
d. Write down 3 contraindications?

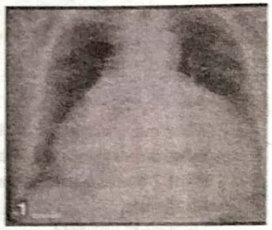


Answer:

a. Liver biopsy needle
b. Chronic hepatitis, cirrhosis, PUO
Biopsy of hepatic lesions, autoimmune hepatitis, Wilson disease, unexplained hepatomegaly, hemochromatosis, persistent raised LFTs
c. Hemorrhage, biliary peritonitis, pneumothorax, right shoulder pain, hemobilia
d. Ascites, local infections, low platlet count, deranged PT

Question 7

a. What is abnormality in this X ray?
b. Write 3 causes of this abnormality?
c. Name 2 other investigation to confirm the diagnosis?



Answer:

a. Cardiomegaly, pericardial effusion
b. IHD, VHD, CMP, uncontrolled HT
c. Echo, ECG

Question 8

a. What is the main finding in this Chest X ray?
b. What are the causes of this finding?
c. Enlist Investigations that are most helpful?

Answer:

a. Right sided pleural effusion
b. TB, Malignancy, Nephrotic syndrome, Pneumonia, parapneumonic effusion, Bronchogenic Carcinoma
c. Pleural fluid DR, Pleural Biopsy, CT Scan with contrast, PCR for DNA of mycobacterium tuberculosis in pleural fluid

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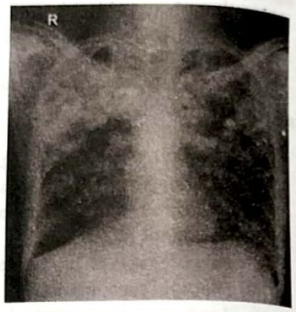
Question 9

a. What is your diagnosis on basis of this Chest X ray?
b. Explain the X ray?
c. Write down treatment of this patient?
d. Write complications of treatment?
e. Write 5 complications this patient develop from this disease?



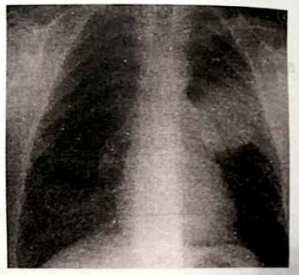
Answer:

a. Pulmonary Tuberculosis
b. Diffuse non homogenous opacities distributed throughout both lung fields
c. 4 Drugs combination of ATT like INH, Rifampicin, Ethambutol and Pyrazinamide for 2 months and followed by 2 drugs INH and Rifampicin for 4 months.
d. Red/ Orange body fluids, Hepatotoxicity, Neurotoxicity, Hyperuricemia, Optic neuropathy (red-green colour blindness)

Pleural effusion, aspergilloma, cavitation, lung abscess, pulmonary fibrosis, Meningoencephalitis

Question 10

a. Write most important finding in X ray?
b. What is most likely diagnosis?
c. Enlist 2 more investigations for the Final diagnosis.
d. Treatment options?



Answer:

a. Homogenous oval opacity near left hilum
b. Cancer bronchus
c. Sputum Cytology, CT Scan chest, bronchoscopy, biopsy
d. Surgical excision, chemotherapy, radiotherapy

Question 11

a. What is the diagnosis?
b. Write steps in management?

Answer:

a. Right lung abscess
b. i. I/V antibiotics for 4-6 weeks
ii. May need bronchoscopic aspiration

Question 12

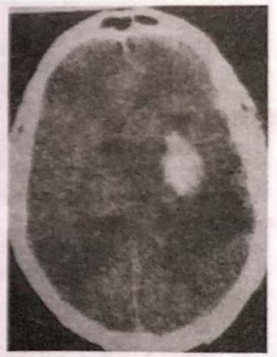
a. Write major positive findings?
b. What is diagnosis?
c. What emergency treatment would you institute in the management of this patient?

Answer:

a. i. Shift of mediastinum towards right
ii. Large penumothorax left
b. Tension pneumothorax
c. Insertion of wide bore canula into left pleural cavity at second intercostals space

Question 13

a. Describe the CT scan findings?
b. What is the diagnosis?
c. Write management steps?



Answer:

a. Hyperdense opacity in left basal Ganglia with surrounding edema And midline shift
b. Intercerebral hemorrhage
c. i. Management of raised ICP
ii. Lowering of BP upto 160/90
iii. Risk factor management
iv. Neurosurgical consult

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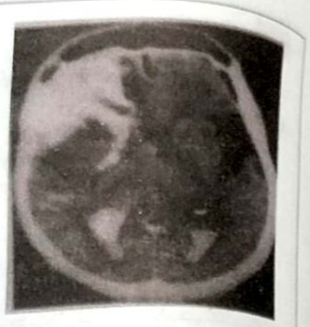
Question 14

a. What is the name of this investigation?
b. Write findings?
c. What is your diagnosis?

Answer:

a. Plain CT Scan of brain
b. Dense opacity in right hemisphere
c. Intra-cerebral bleed with intraventricular extension

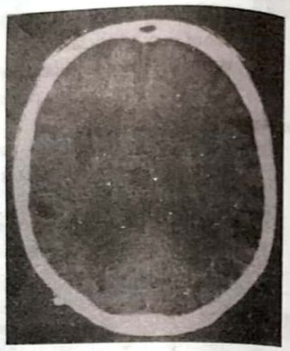


Question 15

a. Write name of the imaging modality?
b. Write abnormal finding?
c. What is the diagnosis?
d. What is the effective treatment?

Answer:

a. CT scan Head without contrast
b. Enlarged lateral ventricles
c. Normal pressure Hydrocephalus
d. Neurosurgical consult , VP shunt



Question 16

a. Name the investigation?
b. Write abnormal finding?
c. Write differential diagnosis?

Answer:

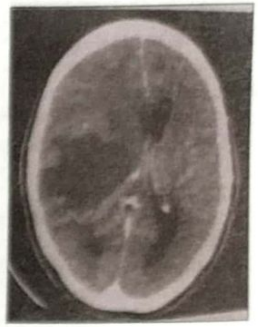
a. CT scan brain with contrast
b. Ring Enhancing lesion in Frontal lobe and Occiptal lobe (B)
c.
- ✓ Brain abscess
- ✓ Tuberculoma
- ✓ Toxoplasmosis
- ✓ Primary brain lymphoma
- ✓ Brain metastases

Question 17

a. Name the investigation?
b. Write abnormal findings?
c. Write risk factors of this disease?

Answer:

a. CT scan brain
b. Hypodense area involving left cerebral Cortex (parietal region)
c. i. DM
ii. Hyperlipidemia
iii.HTN
iv.Cigarette smoking

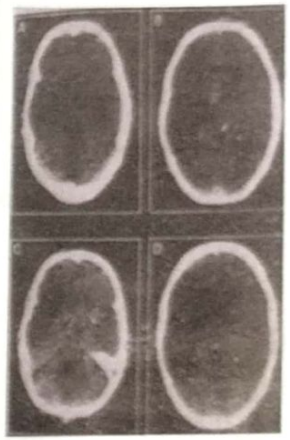


Question 18

a. What is the diagnosis on CT brain?
b. Write risk factors in this patient?

Answer:

a. Large infarct involving right frontal, Parietal and temporal lobe
b. i. Xanthelesma
ii. Atrial fibrillation
iii.HTN
iv.carotid bruit

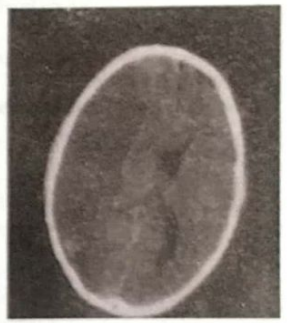


Question 19

a. Write finding of CT scan?
b. What can be possible cause?

Answer:

a. Cerebral infarction/hypodense area
b. Thromboembolism



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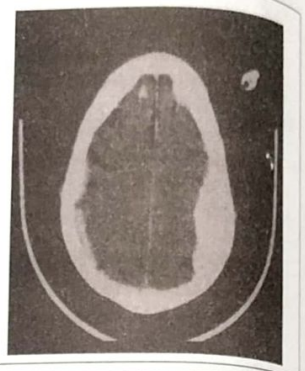
Question 20

a. Write finding of CT scan?
b. What is your diagnosis?
c. Write management?

Answer:

a. Crescent shaped hyper density
On left temporoparietal region
Of brain
b. Subdural hematoma
c. i.ABC care of Unconscious patient
ii. Injection Mannitol
iii.Neurosurgical consultation for
drainage of hematoma

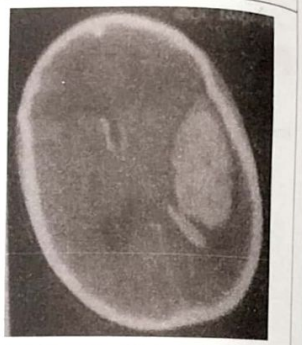


Question 21

a. What is your diagnosis?
b. Write 4 causes?

Answer:

a. Cerebral haemorrhage
b. i.HTN
ii .AV malformation
iii .Aneurysm
iv. Drugs like Cocaine, anticoagulants

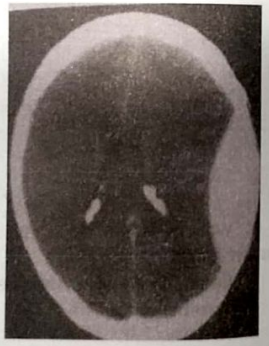


Question 22

a. Write finding of CT Scan?
b. What is your diagnosis?
c. Write management steps?

Answer:

a. Biconvex Hyper density in left Temporoparietal region
b. Extradural hematoma
c. i. ABC care of unconscious patient
ii. Injection Mannitol
iii. Neurosurgical Consultation for drainage of hematoma



Question 23

a. What is your diagnosis?
b. What is immediate treatment
within first 3 hours?
c. What will be the secondary prophilaxis?

Answer:

a. Cerebral Infarction
b. tPA
c. i. Aspirin
ii.BP control
iii.Diabetic control
iv.lipid lowering drugs

Question 24

a. Write findings of CT Scan?
b. What is your diagnosis?
c. Write underlysing pathology?
d. What are possible causes
of this condition?
e. What should be next investigation?
f. Write 3 important management steps?

Answer:

a. Hyper dense streaks in the
Intercerebral fissures
b. SAH
c. Bleeding from circle of willus or berry
Aneurysms
d. i.AV malformations
ii.Berry aneurysm 80%
iii.Connective tissue disease
iv.PCKD
e. Perform LP > 12 hours post headache to see Hanthochromia
f. i. antihypertensive if raised BP
ii.Analgesia or sedation for pain
iii.Nimodipine 60 mg 4 hourly
iv.surgical clipping of aneurysms

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Question 25

a. What are ECG findings?
b. What is the diagnosis?
c. Write management steps?

Answer:

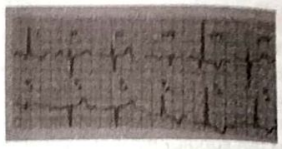
a. ST elevation in V2-V6, I, aVL
Reciprocal ST depression in III and aVF
b. Acute anterior wall STEMI
c. Aspirin
Clopidogrel
Nitrates
Pain relief with Analgesics
Primary PCI/ Thrombolysis

Question 26

a. What are ECG findings?
b. Write Ur diagnosis?
c. Write down 3 causes?

Answer:

a. Widened QRS complex
Left axis deviation
ST depression
Inverted T waves
b. Left Ventricular Hypertrophy
c. i. Systemic arterial HTN
ii. Aortic Stenosis
iii. Aortic regurgitation

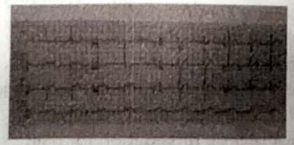


Question 27

a. What are ECG findings?
b. What is the diagnosis?
c. Write management steps?

Answer:

a. ST elevation in II, III, aVF
Q wave formation in III and aVF
Reciprocal ST depression and T wave inversion in aVL
b. Acute Inferior Wall STEMI
c. Aspirin
Clopidogrel
Nitrates
Pain relief with Analgesics
Primary PCI/Thrombolysis



Question 28

Age of patient : 48 yrs
Severe chest pain 6 hours earlier
a. What is your diagnosis?
b. What ECG abnormalities are detected?
c. Write immediate steps of management?

Answer:

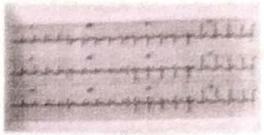
a. Acute transmural inferolateral MI
b. ST elevation and T-wave inversion in inferior leads II, III and aVF and lateral leads V4, V5, V6
c. O2 inhalation, Inj Kinz (Morphine), Thrombolytic therapy

Question 29

a. What are ECG findings?
b. What is your diagnosis?
c. Write management steps?

Answer:

a. Sinus tachycardia
Widespread concaves ST elevation and PR depression (I, II, III, aVF, V4-V6)
b. Pericarditis
c. NSAIDS, treatment of underlying disease, Pericardiectomy

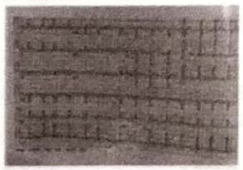


Question 30

a. What is this rhythm called In ECG?
b. Write 3 causes?

Answer:

a. Atrial Fibrillation
b. IHD, Thyrotoxicosis, Mitral Stenosis

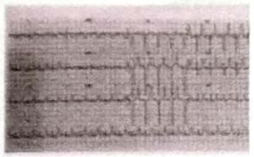


Question 31

a. What are ECG findings?
b. What is your diagnosis?
c. Write management steps?

Answer:

a. Tall peaked T waves
b. Hyperkalemia
c. Calcium gluconate, Insulin, Dextrose
d. Treat the cause of Hyperkalemia



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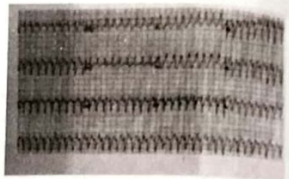
Question 32

a. What are findings of ECG?
b. What is your diagnosis?

Answer:

a. Slightly irregular ventricular rhythm
With a rate of 240
QRS complexes are narrow and
Slurred, upright in V1
b. PVT (Paroxysmal ventricular tachycardia)



Question 33

a. What are ECG findings?
b. What is your diagnosis?
c. Write management steps?

Answer:

a. Absent P waves
Irregularly irregular rhythm
b. Atrial Fibrillation
c. Anticoagulation, Rate/Rhythm control

Question 34

a. Write findings of ECG?
b. What is your diagnosis?
c. Write immediate management steps?

Answer:

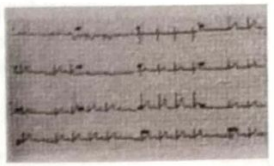
a. Q wave in V1-V4
T wave Inversion
ST segment elevation in V3-V6
b. Acute Myocardial Infarction
c. O2
Dispirin
Analgesics
Thrombolysis

Question 35

a. What are ECG findings?
b. What is your diagnosis?
c. Write management steps?

Answer:

a. Progressive prolongation of PR interval
Culminating in a non-conducted P wave
b. 2nd degree AV block (Wenckebach phenomenon)
c. Temporary or Permanent pacemaker

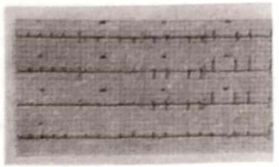


Question 36

a. What are ECG findings?
b. What is diagnosis?

Answer:

a. Flutter rate with atrial rate of 300/mint
b. Variable AV block from 2:1 to 4:1



Question 37

a. What are ECG findings?
b. What is your diagnosis?
c. Write management steps?

Answer:

a. Ventricular rate of 40bpm
Atrial rate of 85 bpm
AV dissociation
b. Complete heart block
c. Permanent pace maker

Question 38

Write causes of Clubbing?

Answer:

Respiratory disease:

1. Chronic suppurative conditions (bronchiectasis, lung abscess, empyema)
2. Carcinoma lung
3. Fibrosing alveolitis

Cardiovascular disease:

1. Cyanotic heart disease (Fallot's tetralogy, transposition of great arteries)
2. Infective endocarditis

Gastrointestinal tract disease:

1. Malabsorption syndrome
2. Crohn's disease
3. Ulcerative colitis
4. Primary biliary cirrhosis

Miscellaneous

1. Familial
2. Pseudoclubbing (it is seen in hyperparathyroidism; there is resortion of terminal phalanx which give impression of clubbing)

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Question 39

A 20 yr old female presented with history of painless swelling of the fingers on exposure to cold. She feel burning sensation on her face. O/e she has butterfly rash on her cheeks along with redness of eye. Swelling of both limbs and ankles.

a. What is your diagnosis?
b. What will be other features of this diagnosis?
c. Write 3 investigations?

Answer:

a. SLE
b. Discoid rash, Oral Ulcers, Seizures, Psychosis, Photosensitivity
c. ESR raised, ANA positive 95-100%, Anti-dsDNA 60%, LE cells 70%, Serum complement low in active disease, In histology deposition of complement.

Question 40

A 55 yr old smoker, obese, diabetic presented with weakness of left side of body.

a. What will be diagnostic?
b. Write 2 investigations?
c. Write treatment?

Answer:

a. Stroke (Left sided Hemiplejia)
b. CT Scan Brain/ MRI Brain
c. Aspirin, Clopedrigol, Thrombolysis, Physiotherapy

Question 41

A 70 yrs old woman presents in the emergency with massive hematemesis. She has history of pain in her knee joints for which she is seeing her orthopedic surgeon who has prescribed her some painkillers. She is pale and tender in her epigastrium.

a. What is your diagnosis?
b. What immediate treatment should be started?

Answer:

a. NASIDS induced erosive and hemorrhagic gastritis
b. i. admit the patient
ii. PASS i.v line
iii.Take Samples
iv.Clinically assess the patient
v.start resuscitation
vi.Give O2
vii.IV Crystalloid infusion
viii.Blood transfusion if neede
ix.Do Endoscopy
x.surgery indicated when endoscopic procedure failed
xi.avoid further use of NASIDS

Question 42

An 18 yr old student is admitted in the Emergency room with severe abdominal pain and persistent vomiting. Examination reveals a dehydrated patient, pulse 120/min regular, BP 100/70 mmHg, respiratory rate 30/min, while the patient is being examined by the surgical registrar; bed side glucose checking on a Glucometer reveals a blood sugar level of 500mg/dl.

a. What is the likely diagnosis?
b. What further Investigations will you order?
c. How would you manage this patient in emergency?

Answer:

a. Diabetic Ketoacidosis
b. Tests: Arterial blood gases, Urine for ketones, Electrolytes
c. Steps:
i.Rehydration with I/V fluids specially 0.9% normal saline (4 6L in 1st 24 hours)
ii.Regular Insulin via Infusion
iii.Correct serum electrolyte accordingly
iv.Correct acidosis if PH below 7.1 and HCO3 less than 10
v.I/V antibiotics

Question 43

Write the long term chronic complications which can occur in future because of uncontrolled blood sugar levels in a 55 yr old diabetic patient?

Answer:

1. Macrovascular complications
a. Cerebrovascular disease/stroke
b. Cardiovascular disease/IHD
c. Peripheral vascular disease/intermittent claudication, amputation
2. Microvascular Complications
a. Retinopathy
b. Neuropathy
c. Nephropathy

Question 44

A 23 year old non diabetic presents with history of paresthesia in arms and legs. On examination, he is markedly pale and has a beefy red tongue; he has got loss of touch, pain, proprioception and vibration in a glove and stocking distribution. His planters are downgoing and ankle reflexes are diminished with preserved other deep reflexes. There are big patches of vitiligo on his trunks and limbs.

a. What is the cause of these symptoms?
b. How will you treat this patient?
c. What is the significance of vitiligo in this patient?

Answer:

a. Vitamin B12 deficiency leading to subacute spinal cord degeneration
b. Give Vitamin B12

Vitiligo is associated with pernicious anemia, so in this patient most probable cause of vitamin B12 is pernicious anemia

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Question 45

A 65 yrs old man presents with low grade fever for six weeks. He also complains of bonepains, weakness and early fatigue. His work up reveals an ESR of 112 mm fall in first hour, Hb 102 g/dl, normal TLC, DLC and platelets. His serum calcium was found to be elevated with a normal alkaline phosphatase. X rays reveals multiple round to oval lytic lesions in his bones.

a. What is most likely diagnosis?
b. What 3 investigations will help make a diagnosis?
c. What 3 specific therapies may be helpful?

Answer:

a. Multiple Myeloma
b. i.increased malignant plasma cells in the bone marrow
ii.serum/urinary paraprotein
iii.skeletal lesion
c. Specific:
i.Chemotherapy
ii.Radiotherapy
iii.Transplantation
iv.Biphosphonates

Question 46

A 50 yrs old man presents to his physician with complaints of electric shock like pain on right side of his face. It is usually triggered in the morning by shaving. Pain does not occur at night.

a. What is the diagnosis?
b. What medical treatment options which are available?

Answer:

a. Trigeminal neuralgia
b. Medical:
i.Carbamazepine 1200mg daily (drug of choice)
ii.Gabapentin, pregabalin & phenytoin are 2nd line drugs
iii.Topical capscaicin can be given

Question 47

Write causes of Ascites?

Answer:

A. Transudative (protein content of ascetic fluid is less than 3.0 gm/dl)
1. Cirrhosis of liver
2. Cardiac disease (right heart failure, constrictive pericarditis, pericardial effusion)
3. 3. Hypoproteinemia (eg nephritic syndrome, malabsorption, malnutrition)
4. Meig's syndrome
5. Budd-Chiari syndrome

B. Exudative (proteins are more than 3.0 gm/dl)
1. Tuberculosis
2. Malignancy
3. Bacterial peritonitis
4. Chemical peritonitis
5. Acute pancreatitis

Question 48

Write causes of splenomegaly?

Answer:

1. Malaria
2. Enteric fever
3. Viral hepatitis
4. Portal hypertension
5. Lymphomas
6. Leukemias
7. Myelofibrosis
8. Hemolytic anemias
9. Military tuberculosis
10. SLE
11. Infective endocarditis
12. Infectious mononucleosis
13. Kala azar

Causes Of Massive Splenomegaly

1. Chronic malaria
2. Chronic myeloid leukemia
3. Myelofibrosis
4. Kala azar

Question 49

Write management of adrenal crisis?

Answer:

. Correct Volume depletion: i/v saline are required, avoid increase of plasma Na
. Replace Glucocorticoides: i/v hydrocortisone suucinate 100 mg state, continue parentera hydrocortisone (50-100 mg) until patient gets well
. Correct Other metabolic abnormalities:
i. Acute hypoglycemia: i.v 10% glucose
ii. Hyperkalemia: should response to volume replacement
. Identify and treat underlying cause:
i. Consider acute precipitant e.g infections (antibiotics)
ii. Consider adrenal or pituitary pathology
. Advice:
i. The dose of glucocorticoid should be kept minimum to avoid side effect
ii. Avoid sudden withdrawal of glucocorticoid therapy
iii. Patient should wear steroids card or bracelet

Question 50

A 25 yrs ill man has attacks of headache, nervousness, palpitation, sweating and apprehension. His blood pressure is usually 170-180/110-120 during these attacks. His examination shows black pigmented spots on the skin.

a. What is the most likely diagnosis?
b. What investigations would you likely to do?

Answer:

a. Pheochromocytoma
b. Investigations:
i. Plasma & urine metanephrine and normetanephrine level (repeated)
ii. 24 hour urinary Vallinylmandeilic acid
iii. Serum Chromogranin A: tumor marker is often elevated
iv. Genetic testing
v. CT/MRI: localization of tumor
vi. Scintigraphy: using Meta-iodobenzyl guanidine (MIBG) for Paraganglioma

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Question 51

A 17 yrs old male presents with c/o puffiness of eyes early morning followed by generalized body swelling. There was no history of hematuria, diarrhea and vomiting. His blood pressure was normal but there was pedal edema, ascites and mild pleural effusion bilaterally. JVP was not raised. His urine examination showed oval fat bodies and proteinuria +++, serum albumin 2.8 g/dl.

a. What is the most likely diagnosis?
b. Enlist investigations you will advise him further.
c. Enlist management steps.

Answer:

a. Nephrotic Syndrome
b. Urine D/R: Proteinuria
   - ✓ 24 hours urinary protein > 3g
   - ✓ Serum albumin level < 3 mg/dl
   - ✓ Total protein level <6 mg/dl
   - ✓ LDL level increased
   - ✓ ESR raised
   - ✓ Blood sugar for DM
   - ✓ ANA for SLE
   - ✓ Serology: Hepatitis B & C
   - ✓ Montoux test to rule out TB
   - ✓ Chest X ray to rule out malignancy
   - ✓ Ultrasound: for renal size to look for renal vein thrombosis
   - ✓ ASO titer to rule out AGN
   - ✓ Renal Biopsy: To Confirm Diagnosis

c. Management:

i. Diet: low salt diet , moderate protein restriction
ii. Diuretics: Furosemide (lasix): 40-120 mg with KCL in moderate to severe edema
iii. HMG-CoA reductase inhibitor: Atorvastatin for hypercholesterolemia
iv. Oliguric renal failure: maintain BP and volume
v. Albumin infusion with mannitol may initiate dieresis
vi. Specific: MCD, Prednisolone 60 mg/day for 8 weeks
vii. Steroid resistant case: cyclophosphamide 3 mg/kg 6-8 weeks
MG: prednisolone & azathioprine, cyclophosphamide, chlorambucil, cyclosporine 6 weeks
FSG: prednisolone 1-1.5 mg/kg/day for 4 weeks & 1 mg/kg/day every other day for 2 weeks in frank nephritic syndrome. Cytotoxic drugs given in refractory cases

Unit 9

SECRETS OF GYNAECOLOGY & OBSTETRICS HIGH YIELD

Question 1

Primigravida at 34 weeks of gestation presenting with complaints of painless vaginal bleeding. On her abdominal examination, abdomen is non tender , head is five by five palpable and fetal heart sounds are normal.

a. What is the most likely diagnosis?
b. How will you manage this patient?
c. Would you like to do the vaginal examination?

Answer:

a. Placenta previa
b. History, examination including general physical/ abdominal examination and on pelvic examination only speculum examination to rule out any local cause of bleeding.
Maternal investigations: FBC, blood grouping, cross match and arrangement of blood, USG for localization of placenta
Fetal Investigations: CTG, USG for fetal well being
Then manage according to the type of placenta previa.
If type 1 placenta previa, then NVD. For type II, III, and IV placenta previa LSCS is recommended.
c. Avoid vaginal examination, allowed only in type I placenta previa

Question 2

A primigravida presents at 36 weeks of gestation with the complaints of reduced fetal movements. Her antenatal CTG and biophysical profile was carried out. What is the normal and reactive CTG?

Answer:

1. Baseline rate: 110-150bpm
2. Baseline variability: 10bpm
3. Accelerations: 15 bpm above normal rate lasting for 15 seconds. 2 acc + sign
4. Deceleration: indicative of hypoxia or umbilical cord compression

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Question 3

A 19 yrs primigravida is brought to antenatal clinic for purpose of obtaining best possible outcome for both mother and child.What investigations you suggest at time of booking visit?

Answer:

Booking Investigations:

1. Full blood count
2. Blood grouping and red cell antibodies
3. Urinalysis
4. Rubella
5. Hepatitis B, C
6. HIV
7. Serological screening test for Syphilis
8. Haemoglobin studies
9. Cervical smear and vaginal swab only in case of abnormal cervix
10. Random blood sugar to screen DM

Question 4

a. What is CTG? What are the features of normal CTG?
b. What is stress and non stress CTG?

Answer:

a. Cardiotocography (CTG) is continuous tracing of fetal heart rate used to assess fetal well being.
Features of normal CTG:
   i. Baseline rate: 110-150bpm
   ii. Baseline variability: 10 bpm
   iii. Accelerations: 15 bpm above normal rate lasting for 15 seconds. 2 acc + sign
   iv. Deceleration: indicative of hypoxia or umbilical cord compression

b. Stress CTG: CTG carried out during some kind of fetal stress is called stress CTG.
Non stress CTG: CTG carried out in the absence of any stress is called non stress CTG.

Question 5

A young multigravida is worried for screening tests. Comment on the utility of various antenatal screening methods.

Answer:

Antenatal screening tests:

1. CBC (anemia, thrombocytopenia)
2. Blood grouping (Rhesus D iso-immunization, hemolytic disease)
3. RFTs (Urea and Creatinine)
4. Serology (Hepatitis B, C, Syphilis, Rubella)
5. Other Screening: for bacterial vaginosis, CMV, Toxoplasmosis
6. Blood Sugar levels (Gestational DM)
7. Ultrasonography

Question 6

A 24 yr old primigravida presented to you with history of 6 weeks gestational amenorrhea and vaginal bleeding for 1 day. Her urine pregnancy test is positive. She has severe lower abdominal pain for 2 hours, she also had syncopial attack at home. On pelvic examination she is very tender and her B.P is 100/60 with thread pulse.

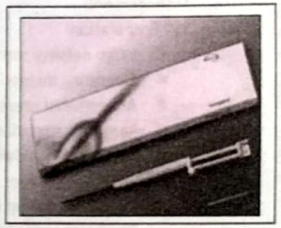
a. What is the most likely diagnosis?
b. How will you confirm the diagnosis?
c. How will you manage the patient?

Answer:

a. Ectopic Pregnancy
b. 1. Ultrasonography preferably (TVS) small uterus for gestational age with no gestational sac or small pseudo sac(decidual reaction) on TVS Adenaxal gestational sac or mass with or without pelvic fluid on TVS.
2. Serum BHCG level. Normal or low for gestational age (discriminatory level)
c. Management:
   ✓ Admit her, do all investigations and arrange blood
   ✓ Counsel her and relative regarding the situation
   ✓ Salpingectomy (removal of the tube and gestational sac) or salpingostomy (opening of the tube and removal of the Gestational sac only) via laproscopy if the gestational sac is intact and no signs of rupture or by laparaotomy if the patient is in shock.

Question 7

a. What is shown in photograph?
b. Write uses of it?
c. Write side effects of it?



Answer:

a. Implanon
b. Used for contraception
c. Menstrual irregularities, weight gain
Headache, mood swings, acne depression
Other possible side effects are vaginal inflammation or dryness, breast pain, stomach or back pain, nausea, dizziness and pain where the implant was inserted.

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Question 8

A primigravida at 34 weeks of gestation confirmed by ultrasound presents with decreased fetal movements for last two days. On abdominal examination, the fundal height is 30 weeks with longitudinal lie and cephalic presentation. The fetal heart rate is 130 beats/mint.

a. What is the most likely diagnosis?
b. Outline the plan of management?

Answer:

a. IUGR (intrauterine growth retardation)
b. Management:
   1. Identification of cause
   2. Asses the fetus by best ways
   3. Deliver the baby at right time
   4. Counseling
   5. Follow up

Question 9

A G3P2+0 at 37 weeks comes with labour pain 2 hour. She is diagnosed to have a twin pregnancy and 1st twin is breach.

a. How will you manage her?
b. What is the criterion for twin labour?

Answer:

a. Management:
   1. Preparation:
      - ✓ Large delivery room
      - ✓ Operating theater and staff ready
      - ✓ Anaesthetist present
      - ✓ Senior Obstretician present
      - ✓ At least two midwives present
      - ✓ Twin resuscitaires
      - ✓ Ventouse/ forcep to hand
      - ✓ Blood grouped and saved
      - ✓ I.V access
      - ✓ Neonatalogist present
      - ✓ Pre-mixed oxytocin infusion ready
   2. Analgesia during labour
   3. Fetal wall being in labour
   4. Vaginal delivery of vertex-vertex
   5. Delivery of vertex-non vertex
   6. Non-vertex 1st twin
   7. Manage postpartum hemorrhage

b. Most reliable is 1st trimester USG. Assesment of fetal gender, number of placenta, characteristic of membrane

Question 10

A primigravida at 38 week presents in emergency with tonic clonic fits. On examination blood pressure wa 180/120 mmHg with generalized edema.

a. What is your diagnosis?
b. What will be drug of choice for fits in this patient?

Answer:

a. Eclampsia
b. Drug of choice for fits in this patient is MgSO4

Question 11

A 25 yr old female in her 5th pregnancy is seen in an antenatal clinic at 20 weeks gestation. Hemoglobin concentration on routine blood test reveals 7.2 gm/dl.

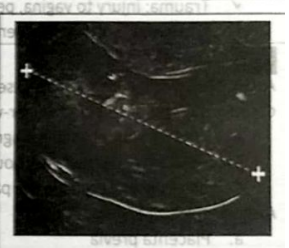
a. What is your diagnosis?
b. What investigations you will ask to confirm your diagnosis?
c. Justify management.

Answer:

a. Iron deficiency anemia
b. Investigations:
   CBC, Serum ferritin level, TIBC, Iron level, Peripheral morphology (microcytic hypochromic anemia)
c. Management:
   - ✓ Oral iron can be given upto 28 weeks ferrous sulphate or ferrus fumarate
   - ✓ Parenteral iron, iron sucrose complex for 3 weeks
   - ✓ Blood transfusion if Hb 8mg/dl
   - ✓ Treat the associated causes

Question 12

a. Which measurements are taken?
b. Give 2 indications of this measurement?
c. What is prediction of its accuracy?



Answer:

a. CRL measurement of fetus
b. For measuring:
   - ✓ Gestational age
   - ✓ Calculating EDD
c. Early CRL is accurate by prediction of +- 5 days

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Question 13

An obese 35 yrs old primigravida is found to have two episodes of glycosuria in the second trimester.

a. What are causes of glycosuria in pregnancy?
b. How will you confirm the diagnosis?

Answer:

a. Causes:
- ✓ Increase GFR
- ✓ Resorptive mechanism in proximal renal tubule may become saturated
- ✓ Gestational diabetes

b.
- ✓ Blood sugar random
- ✓ Blood sugar fasting
- ✓ Glucose intolerance test (GTT)
- ✓ HbA1c

Question 14

A P1+0 presents in emergency room with secondary post partum hemorrhage (PPH) after delivery.

a. Define secondary PPH.
b. Enlist causes of secondary PPH.

Answer:

a. Secondary PPH: loss of > or equal to 500 ml blood from the genital tract b/w 24 hours 12 weeks post delivery.
b. Causes of PPH:
- ✓ Tone: uterine atony
- ✓ Tissue: retained placenta and or membrane
- ✓ Trauma: injury to vagina, perineum and uterine tears at c-section
- ✓ Thrombin: clotting disorders

Question 15

A G3 P2+0 with previous two C-section has presented in emergency at 35 weeks of gestation with the complaint of painless bleeding per-vaginum for last two hours. Her vitals signs are normal.

a. What is your probable diagnosis?
b. What investigations will you advice?
c. How will you manage the patient?

Answer:

a. Placenta previa
b. Investigations:
- ✓ USG
- ✓ CT scan
- ✓ CBC
- ✓ Blood grouping

c. Management:
- ✓ Resuscitate the patient using structured approach of ABC
- ✓ Maintain IV line
- ✓ Blood transfusion
- ✓ Prepare for delivery
- ✓ In case of major bleeding C-section

Question 16

You are called out to evaluate a young lady delivered two days ago whom the family describes as "depressed". She is physically okay, has a healthy alive son. What are the psychiatric ailments in puerperium? What can you do for her?

Answer:

1. Depression (major, moderate, minor)
2. Puerperal psychosis
3. Postpartum blues

Treatment:
- ✓ Admit in ward
- ✓ Remedy of social factors
- ✓ Non-directive counseling
- ✓ Interpersonal psychotherapy
- ✓ Cognitive-behavioural therapy
- ✓ Drug therapy (TCA, SSRIs)

Question 17

A P2+0 has presented on the 4th postnatal day normal vaginal delivery with complaint of 102 F fever, rigors, chills and red hot and tender left breast.

a. What is the most probable diagnosis?
b. What investigations will you advise?
c. How will treat her?

Answer:

a. Mastitis of left breast
b. Investigations:
i. Microbiological culture & sensitivity of milk
ii. Mammography
iii. USG
c. Treatment:
1. Isolation of mother and baby
2. Breast feeding cessation
3. Expression of milk either manually or by electric pump
4. Antibiotics: Flucloxacillin can be given
5. Radical surgical incision & drainage under G/A in case of abscess

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Question 18

A P2+0 delivered by you decided not to breast feed her baby
How will you counsel her regarding breast feeding?

Answer:

Counselling:

1. Inform all pregnant women about the benefits and management of breastfeeding
2. Help mothers initiate breastfeeding with half an hour of birth
3. Show mothers how to breastfeed
4. Give new born infants no food or drink other than breast milk unless medically indicated
5. Practice rooming in 24 hours a day
6. Encourage breastfeeding on demand
7. Give no artificial teats or pacifiers to breast feeding infants
8. Continue breastfeeding at least 6 months

Question 19

A 22 yrs old woman married for one yr, presents with amenorrhea of six weeks, lower abdominal pain and vaginal bleeding for one day. Her urine for pregnancy test is positive & on TVS, uterus is empty and there is right adnexal mass of 2.5 x 1.5cm.

a. What is the most probable diagnosis?
b. Give 4 differential diagnoses.
c. What are the selection criteria for medical management?

Answer:

a. Ectopic Pregnancy
b. . Spontaneous abortion
. Ovarian cyst
. Acute PID
. Sub serous fibroid

c. Selection criteria for medical management:

i. Unruptured tubal pregnancy less than 3cm in diameter
ii. Absent hemo-peritoneum
iii. Sonographically non visible pregnancy
iv. Beta HCG level less than 2000 IU/L

Drugs:

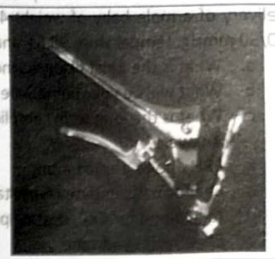
- ✓ Methotrexate
- ✓ Actinomycin local 50mg/m2
- ✓ Misoprostol
- ✓ Mifeprostone
- ✓ Hyper-osmolar glucose
- ✓ 20% KCl

Surgical:

- ✓ Laparoscopy or Laparotomy
- ✓ Prevention:
- ✓ Avoid sexual intercourse
- ✓ Avoid alcohol
- ✓ Avoid exposure to sunlight

Question 20

a. What is instrument shown in picture?
b. What it is used for?
c. Write indications?



Answer:

a. Cuso/ (bivalve) speculum
b. For the visualization of the cervix and the vaginal walls
c. Indications:
   - ✓ Visualization of cervix
   - ✓ Taking pap smear
   - ✓ Removal of IUCD
   - ✓ Insertion of IUCD
   - ✓ Removal of polyp
   - ✓ Cervical cautery
   - ✓ To obtain samples of the discharges from the cervix and vagina

Question 21

a. What is the procedure shown in pictures?
b. What is it used?
c. What is ideal time to do this test?
d. What are its complications?

Answer:

a. Hysterosalpingogram
b. To see the patency of fallopian tubes and to seek out any uterine cavity or tubal abnormalities
c. Day 8th to 10th of menstrual cycle in order to avoid inadvertent exposure of the early embryo to the ionizing radiation
d. i. Dye allergy
ii. Infection if aseptic technique
iii. Very rarely uterine perforation

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Question 22

A 36 yr old Mrs. Sadia P6A1 presented in emergency with complaint of heavy vaginal bleeding after delivery of a male baby of weight 4 kg at home 2 hours back. On examination her pulse is 120bpm, BP 80/50 mmHg, temperature 98.6 F and R/R 24/mint. On abdominal examination uterus is relaxed

a. What is the most likely diagnosis?
b. What will be your immediate step?
c. What is the long term complications of such severe condition?

Answer:

a. PPH due to uterine atony
b. Call for help, initiate resuscitation and check air way, start 100% oxygen, save 2 wide bore I/V lines, take blood for CBC, clotting profile and cross matching of 4 unit of blood
c. Sheehan's syndrome

Question 23

A primigravida at 34 week of gestation presented with H/O BP 140/100 mmHg protein urea +++. She had fits for last 3 hours.

a. What is diagnosis?
b. What specific investigation you will perform in her case?
c. Outline management plan?

Answer:

a. Eclampsia
b. i.Liver function tests
ii.Renal function test (urea,creatinine)
iii.24 hour urinary protein/creatinine clearance
iv.Coagulation profile (Platelet count, PT, APTT)
c. Management:
✓ Admit the patient
✓ Take detail history from relatives and side by side manage the patient
✓ Turn the woman on her side with hyer head down
✓ Maintain air way, give oxygen by face mask, save I/V line, draw blood for investigation
✓ Start Magnesium Sulphate 5 mg I/V bolus and then maintain dose for 24 hours
✓ Start antihypertensive; keep systolic BP below 160 mmHg and diastolic 100-110 mmHg
✓ Deliver the patient once stable and asses condition of fetus by USG and CTG. If viable preferably deliver patient by cesarean section and if in labour progressing well the deliver vaginally otherwise, if fetus is dead then induction of labor with good bishop score can be tried. Aim is to deliver the patient within 8 hours of fits.

Question 24

A 35 yr old nulliparous Mrs. Shaista presented to you with history of excessive cyclic vaginal bleeding for 1 yr. She also complained of frequency of micturation since 6 months. On examination abdomen is distended with 20 weeks size firm mass arising from the pelvis. USG done showed 12 x 10 cm mass arising from the posterior wall of the uterus and also distorting the endometrial cavity.

a. What is the diagnosis?
b. What is the risk factors for the condition?
c. What is the treatment options for this woman?

Answer:

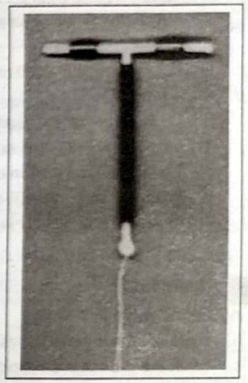
a. Fibroid uterus
b. Nuliparity, Obesity, a positive family history and African racial origin & age 20-35 yrs of age
c. Conservative management with:
✓ Medical therapies, antiprostaglandins, GnRh analogues
✓ Uterine artery embolization
✓ Myomectomy

Question 25

a. Identify the specimen.
b. What is its mode of action?
c. What are contraindications?

Answer:

a. Copper T (an IUCD)
b. Mode of action:
✓ The arms of the Copper-T IUCD contain copper, which stops fertilization by preventing sperm from making their way up through the uterus into the fallopian tubes.
✓ If fertilization does occur, the IUCD would prevent the fertilized egg from implanting in the lining of the uterus
c. Contraindications:
i. PID
ii. Previous Ectopic pregnancy
iii. Known malformation of uterus
iv. Copper allergy



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Question 26

A 38 yr G6P5 presented with history of 22 week gestational amenorrhea with fundal height of 28 weeks. She is unable to feel fetal movement till now her ultrasound done yesterday, this showed snow storm appearance and absent fetus.

a. What is the diagnosis?
b. What is etiology?
c. What is its incidence?
d. How you will manage her?

Answer:

a. Hydatidiform mole
b. Etiology:
   - ✓ Extreme of maternal age (age less than 16 yrs and more than 40 yrs)
   - ✓ Previous history of molar pregnancy
   - ✓ Multiparity
   - ✓ Lower socioeconomic group on a poor rice diet
   - ✓ Dietary deficiency in protein, folic acid and iron
   - ✓ ABO blood group of parents. Blood Group A women are at the higher risk than blood group O women

c. Incidence 1 per 1000-2000 pregnancies
d. Management:
   - ✓ Counsel the patient. Explain the condition its risk and complications and treatment options
   - ✓ Sent serum BHCG and explain its significance
   - ✓ Explain Surgical suction evacuation under general anesthesia
   - ✓ Following surgery BHCG fortnightly until undetectable and then monthly till 6 months in partial mole and for one year in complete mole

Question 27

a. Define abortion.
b. What are the different types of abortion?
c. What are the common etiological causes of abortion?

Answer:

a. Define as pregnancy that deliver before 24 weeks of gestation or of less than 500gms weight
b. Types:
   - ✓ Threatened miscarriage
   - ✓ Missed abortion
   - ✓ Inevitable miscarriage
   - ✓ Recurrent miscarriage

c. Chromosomal abnormalities:
   - ✓ Endocrine disorders
   - ✓ Abnormalities of uterus
   - ✓ Infections
   - ✓ Chemical agent
   - ✓ Psychological disorders

Question 28

A primigravida, 25 yr old known cardiac patient with mitral stenosis admitted in the labour ward with history of 39 week gestation. How will you manage her during labour?

Answer:

Management:

1. Multidisciplinary approach involve the cardiologist
2. Avoid induction and wait for spontaneous onset of labour if possible
3. Give prophylactic antibiotics
4. Ensure adequate fluid balance
5. Avoid the supine position
6. Give regional/epidural analgesia during labour
7. Shorten the second stage of labour
8. Avoid the use of ergometrine
9. Use syntocinon judiciously

Question 29

A G2 P1 at 39+4 day of gestation presented in the labour ward with history of bleeding vaginally. What are the most likely causes?

Answer:

1. Placenta previa
2. Placental abruption
3. Vasa previa
4. Trauma to the genital tract
5. Labour (heavy show)

Question 30

Give any 4 indications for induction of labour?

Answer:

1. Post dates (i.e 12 days or more beyond EDD)
2. Fetal growth restrictions or placental insufficiency e.g oligohydramnios
3. Preeclampsia/hypertensive disorder of mother
4. Deteriorating maternal illness
5. Prolonged prelabour rupture of membrane
6. Diabetes mellitus
7. Social reasons Rhesus iso-immunization

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Question 31

A P7 presented in emergency in state of shock following home delivery one hour back. Write down basic steps involved in resuscitation of patient in shock.

Answer:

1. Save 2 IV lines
2. Maintain airway
3. Left lateral position & give oxygen
4. Maintain blood volume by crystalloids or colloid
5. Take blood for Hb, blood grouping, cross matching, coagulation and renal profile
6. Arrange 4 units of blood
7. Catheterization for monitoring of urine output

Question 32

A 28 yr old female with body mass index of more than 30, presented in the OPD, with the complaints of hirsutism and oligomenorrhea.

a. What is the diagnosis?
b. What are the USG criteria for diagnosing the condition?
c. What is the treatment options for such condition?

Answer:

a. PCO
b. Ten or more peripheral cysts of sizes between 2-8 mm of diameter (string of pearl's sign)
Increased ovarian stromal volume to > 8cm3
c. For obesity .... Weight loss
For menstrual irregularities ... Cyclic progesterone or combined OCP
Hirsutism and acne ... anti-androgen along with OCP
Cosmetic therapy such as waxing and bleaching or laser removal of hairs
Infertility.... Ovulation induction
Hyper insulinemia antidiabetic drug like metformin

Question 33

A G 3 P1+1 at 12 week of gestation presented to you in the OPD for routine antenatal checkup. Her blood group is B negative. During history she told that her last child was mildly jaundiced following birth and he got some phototherapy.

a. What is the likely cause of jaundice in her baby?
b. How will you manage her during this pregnancy?
c. What could be the effects of rhesus disease on the fetus?

Answer:

a. Physiological Jaundice or Rh disease
b. Management:
   - ✓ Ask for husband blood group if husband blood group also negative ... do nothing reassure patient.
   - ✓ If husband blood group positive...

i. Ask history of Anti D in previous pregnancies
ii. Do indirect coombs test on maternal blood to detect antibodies
   - ✓ If no antibodies... give prophylactic intramuscular anti D at 28 weeks and /or 34 week or a least post delivery within 72 hours (must be given)
   - ✓ If indirect coombs test positive, look for antibody level at 2-4 week intervals if remain below 1 iu/ml baby is less likely to be effected, just keep patient under observation and pressure.
   - ✓ But if antibody titre > 10 iu/ml refer to fetal medicine centre to check for early sign of feta anemia by ultrasound and if required by invasive assessment and management accordingly.

c. In utero fetal effects are

In mild disease...may be no effect or baby mildly effected

In moderate to severe disease ... may be

- ✓ Fetal anemia (Hydrop fetalis)
- ✓ Polyhydramnios
- ✓ Enlarged fetal heart
- ✓ Ascites and pericardial effusions
- ✓ Hyperdynamic circulation in middle cerebral arteries
- ✓ On Doppler USG
  - ➢ Reduced fetal movement
  - ➢ Sinusoidal pattern at CTG

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Question 34

a. What is meant by biophysical profile?
b. What is its component?
c. Give 4 indications for its use.

Answer:

a. A biophysical profile is a prenatal ultrasound evaluation of fetal well being, involving scoring system

b.
- ✓ The biophysical profile (BPP) has 5 components: 4 ultrasound (US) assessments and nonstress (NST)
- ✓ The nonstress test (NST) (CTG) evaluates fetal heart rate and response to fetal movement
- ✓ The BPP (ultrasound) measures fetal heart rate, muscle tone, movement, breathing and the amount of amniotic fluid

c. Indications:
- ✓ Hyperthyroidism
- ✓ Bleeding problems
- ✓ Lupus anticoagulant
- ✓ Type 1 diabetes or gestational diabetes
- ✓ High blood pressure (hypertension)
- ✓ Preeclampsia
- ✓ A small amount of amniotic fluid (oligohydramnios) or too much amniotic fluid (polyhydramnios)
- ✓ A multiple pregnancy (such as twins or triplets)
- ✓ A pregnancy that has gone beyond due date between 40 and 42 weeks

Question 35

A 24 yr primigravida presented to you with history of 6 weeks gestational amenorrhea and bleeding vaginally since 1 day. Her urine for pregnancy tests is positive. She has severe lower abdominal pain since 2 hours. On examination her abdomen is tender and on pelvic examination cervical excitation positive. Her BP is 100/60 with thread pulse.

a. What is most likely diagnosis?
b. How will you confirm the diagnosis?
c. How you will manage the patient?

Answer:

a. Ectopic pregnancy
b. By ultrasonography preferably (TVS) and serum BHCG quantitative (low for gestational age)
c. Admit her
- ✓ Counsel her and relative regarding the situation
- ✓ Take informed consent
- ✓ Arrange blood
- ✓ Salpingectomy (removal of the tube and gestational sac) or salpingostomy (opening of the tube and removal of the gestational sac only) via laparoscopy or laparotomy

Question 36

An 18 yr old G2P1 at 30 weeks of gestation presented to you in the labour ward with history of labour pains since 6 hours. On abdominal examination uterus corresponds to dates, contracting after every 3-4 minutes on speculum examination cervical os 3 cm dilated fully affected, membrane intact.

a. What is the diagnosis?
b. What are the risk factors for preterm labour?
c. What are mamngement options for preterm labour?

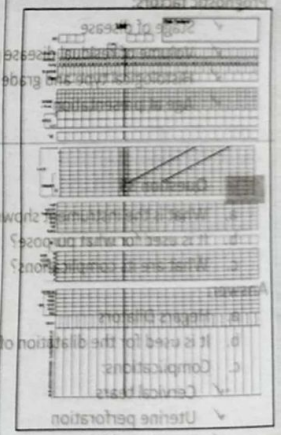
Answer:

a. Preterm labour
b. Risk factors:
- ✓ Previous preterm birth 20% risk
- ✓ Twin pregnancy
- ✓ Teen age pregnancy
- ✓ Uterine anomalies
- ✓ Congenital anomalies
- ✓ Cervical damage (cone biopsy, repeated dilatation)
- ✓ Poor socio-economic status
- ✓ Smoking
- ✓ Drug abuse

c. Management options:
- ✓ Tocolysis
- ✓ Steroid Cover
- ✓ Inform neonatal unit
- ✓ In-utero transfer if neonatal services not satisfactory

Question 37

a. What is shown in diagram?
b. It is used for what purpose?
c. What important features of labour are noted on it?



Answer:

a. Partogram
b. It is used to make the graphic record of the labour which show the progress of labour
c. Features noted are:
- ✓ Patient profile
- ✓ Patient vital signs
- ✓ Fetal heart rate
- ✓ Uterine contractions (strength, duration and intensity)
- ✓ Descent of fetal head
- ✓ Dilatation of the cervix
- ✓ Colour of the liquor
- ✓ Drugs and I/V fluid

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Question 38

A 32 yrs old P3+0 woman comes with weight loss 6 months, abdominal distension 6 months. She complains of indigestion and urinary frequency. Her abdominal examination shows firm to hard mass reaching into umbilicus.

a. What is your diagnosis?
b. What are the investigations and management

Answer:

a. Ovarian carcinoma
b. Investigations:
- ✓ CBC
- ✓ Urea & electrolyte
- ✓ LFTs
- ✓ Chest X ray
- ✓ X ray abdomen
- ✓ USG
- ✓ CT Scan or MRI abdomen
- ✓ Biopsy
- ✓ Tumor marker Ca-125

Treatment:

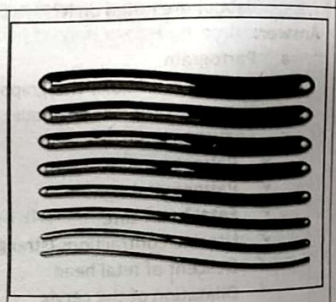
1. Surgery: total abdominal hysterectomy + bilateral salping-oophorectomy + infracolic omentectomy + lymph nodes resection
2. Chemotherapy: carboplatin + paclitaxol
3. Radiotherapy
4. Follow up: Clinical examination + Ca 125 measurement

Prognostic factors:

- ✓ Stage of disease
- ✓ Volume of residual disease post-surgery
- ✓ Histological type and grade of tumor
- ✓ Age at presentation

Question 39

a. What is the instrument shown in picture?
b. It is used for what purpose?
c. What are its complications?



Answer:

a. Hegars Dilators
b. It is used for the dilatation of cervical os
c. Complications:
- ✓ Cervical tears
- ✓ Uterine perforation
- ✓ Creation of false passage
- ✓ Excessive cervical dilatation may lead to cervical incompetence

Vaginal Specula

(1) Cusco's non-fenestrated bivalvular self-retaining vaginal speculum

Indications:

1. It is used during clinical examination to expose the cervix and vaginal walls.
2. It allows the application of local treatment to the cervix.
3. It allows introduction of the uterine sound, insertion of IUD, performing hysterosalpinogography, taking premenstrual endometrial biopsy, surface biopsy scraping of the cervix ... etc.
4. It is used to expose the two sides of a septet vagina, when a blade is inserted in either side.

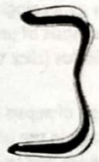
Advantages:

1. Easy to introduce.
2. Self-retaining.
3. Can be adjusted to the size of the vagina.

Disadvantages:

1. It hides the anterior and posterior vaginal walls; however, this disadvantage is overcome by inspection of the vaginal walls during its gradual withdrawal.
2. It doesn't offer complete protection of vaginal walls during cauterization of the cervix.

Sim's vaginal speculum



Indications:

1. Expose the anterior vaginal wall especially in cases of vesico-vaginal fistula, both for diagnosis (prolapse) and for operative repair (episotomy).
2. It can also be of value to insert a vaginal pack.

Advantages:

1. Gives an excellent view of the anterior vaginal wall.
2. The grooved blade directs the blood or urine outside when used in the lithotomic position, and provides a space for operative work.

Disadvantages:

1. Assistance is required especially when used to expose the cervix or during surgical procedures, as it is not self-retaining.
2. In the presence of a large cystocele, exposure of the cervix is often difficult.

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Auvard's self-retaining vaginal speculum

Indications: most operations performed per vagina.

Advantages:

1. It is self-retaining.
2. It gives good exposure of the anterior vaginal wall and cervix during operations

Disadvantages:

1. It may tear, bruise or overstretch the soft tissues of the perineum and posterior vaginal wall.
2. It is difficult to use in nulliparae
3. It hides the posterior vaginal wall.

Metal Urinary Catheter

These are of two forms: the straight and the curved (S-shaped)

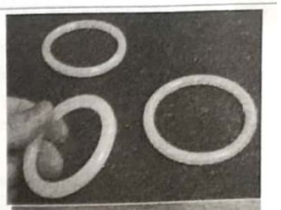
Indications:

- ✓ In the 1 and
- ✓ In the 3 stage of labor to prevent uterine inertia
- ✓ stage of labor to prevent retention of the placenta and guard
- ✓ Gaurd against post-partum hemorrhage
- ✓ Before any gynecological or obstetrics examination
- ✓ For the diagnosis of urinary fistula
- ✓ Vesicle calculus (click sound)

Complication

- ✓ Introduction of sepsis
- ✓ False passage in the urethra or perforation of bladder wall
- ✓ Urethral shock and fever

Hodge Pessary



Indications:

1. Symptomatic uterine prolapsed
2. Pelvic support defects
3. Vaginal Prolepses

ContraIndications:

1. Active infections of the pelvis or vagina.
2. Patients who are noncompliant or unlikely to follow up.
3. Allergy to the product.

Follow Up:

After the initial fitting of the pessary, the patient should be followed-up within a few days so that the physician can recheck the fit. The pessary should be removed so that the vagina can be examined for irritation, pressure sores or allergic reaction. Having to change the size of the pessary at least once after the initial fitting is not uncommon.

The patient should then be instructed to follow-up within one to two weeks for another examination, after which time the examinations can be spaced to every two to three months. In the motivated patient who is able to demonstrate effective removal, insertion and care of the pessary, these examinations may be spaced further at the discretion of the physician.

At each follow-up examination, the pessary should be removed and cleaned with soap and water while the vagina is inspected for erosions, pressure necrosis or allergic reaction. If inspection of the pessary reveals cracking or other defects, it should be replaced. The patient who is using a pessary should be considered to be under the care of the person who placed it for the duration of its use. Pessaries should never be placed in elderly, debilitated patients without excellent follow-up.

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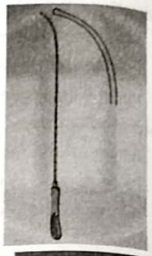
Sims Uterine Sound

- ✓ Graduated in centimeters or in inches.
- ✓ Malleable (can be bent and twisted easily)
- ✓ Corrugated handle (during insertion they should face upwards)
- ✓ The whole diameter = 3mm, the diameter of the knob = 4 mm



Indications:

1. Measures the length of the cervical canal, the uterine body and that of the whole uterus (before D&C and after insertion of an IUCD)
2. To determine the direction of the uterus. (RVF: the corrugations on the handle will face downward after it was facing upwards)
3. To differentiate uterine inversion from a submucous fibroid.
4. Differentiate between a uterine polyp (can go around it) and a cervical poly (cannot go around it)
5. It determines the relation of the uterus to any pelvic mass.
6. It differentiates true from pseudoprolaspse (congenital elongation of the cervix). The sound is inserted into the lateral vaginal fornix and its relation to the ischial spines is evaluated.
7. To diagnose vesico-vaginal fistula. The sound is passed through the fistulous opening in the vagina where a click is elicited against a metal catheter in the urinary bladder.
8. Missed loop: insert the uterine sound then do X-ray, if the IUCD is far away from the sound. The IUCD has perforated out of the uterus. If the sound is close to the IUCD. The IUCD is inside the uterus
9. To diagnose a bicornuate uterus, a uterus septus, and a uterus subseptus (uterine anomalies).
10. Cervical stenosis
11. 1º dysmenorrhea
12. Probe test of friability for cancer cervix (Krobac's test).

How to Use:

1. The uterine sound is inserted through the cervix
2. The first resistance is the internal OS ⍰⍰length of the cervical canal
3. The second resistance is the uterine fundus ⍰⍰length of the uterus + the cervix

Complications:

1. Disturbance of an undiagnosed pregnancy
2. Perforation of the cervix or body of the uterus
3. Ascending infection

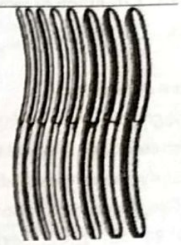
Contraindications:

1. Genital infections 2. Suspicion of pregnancy
3. Soft uterus (malignancy, infection, molar pregnancy).

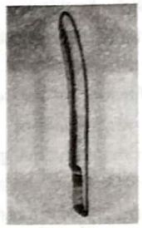
Hegar's Uterine Dilators

- ✓ They are used to gradually dilate the cervix
- ✓ They can be single or double ended
- ✓ Uniform thickness
- ✓ There are 15 Hegar dilators, graduated by a number written on them ranging from 0-14 which corresponds to the thickness in millimeters.
- ✓ The tip is slightly curved.
- ✓ They are held between the index and the thumb at a level less than the uterine length

Double-ended Hegar Uterine Dilator 3-18mm



Single Ended Hegar's Uterine Dilator.



Indications for cervical dilatation:

A) Diagnostic

1. Incompetent internal os. The passage of dilator no. 8 through the internal os without causing pain or meeting with resistance signifies incompetence.
2. Before the exploration of the uterine cavity for diagnosis of intrauterine lesions and septa.
3. As a preliminary step to diagnostic curettage of the endometrium.
4. Prior to insufflations or hysterosalpingography in cases with a narrow external os.
5. For diagnosis of spasmodic dysmenorrhea; the passage of no. 4 Hegar's dilator causes severe pain when it reaches the internal os.

B) Therapeutic

1. Dysmenorrhea: the idea is that dilatation (at least to No.14) act as a local sympathectomy by cutting the nerves at the internal os.
2. Spasmodic amenorrhea
3. Drainage of hematometra or pyometra.
4. In some cases of sterility with a pin hole external os.
5. Stenosis of the cervix, e.g. post-operative or post-cauterisation.
6. Cervical abortion.

C) As a step in the course of other operations

1. Preliminary to curettage or evacuation.
2. A step in the management of vesicular mole and certain types of abortions: (a) Missed abortion.
(b) Therapeutic abortion.
3. Vaginal hysterotomy.
4. Removal of fibroid or endometrial polyps.
5. Cervical conization, amputation, Fothergill's operation and

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trachelorrhaphy.
6. Before insertion or removal of certain contraceptive devices.

Degree of dilatation:
The degree of dilatation is governed by the indication:
1. For curettage dilate to no. 10-14
2. For dysmenorrhea dilate to 14-16.
3. For finger exploration and digital separation of a conceptus dilate to no. 18-22 (varies according to the diameter of the operator's finger).

Contraindications:
1. Genital infections.
2. Normally pregnant uterus.

Complications:
1. Perforation of the cervix or body of the uterus. It is sequel to forceful manipulations in a wrong direction. Pregnancy, vesicular mole and malignancy increase the chances for perforation because of the soft and friable uterine wall.
2. Lacerations of the cervix.
3. Cervical incompetence and habitual abortion. (most common)
4. Ascending infection (cervicitis, endometritis, salpingitis, peritonitis and parametritis)
5. Endometriosis results from the piston like action of the dilator which pushes endometrial fragments through the tubal osria.

Vulsellum Forceps

Types:
1. Single toothed (bullet forceps) Tenaculum
2. Double toothed (Fenton's bull-dog vulsellum or the lion's forceps)
3. Multiple toothed vulsellum (Tenaculum)

Indications:
1. Grasping of the cervix
(a) During minor office practice manipulations, e.g. insersion os a uterine sound, or an IUCD in difficult cases and during insufflation and hysterosalpingography.
(b) To estimate the degree of uterine descent in cases of prolapse by pulling on the cervix downwards and observing the level to which it reaches
(c) To evaluate the mobility of the uterus; this may be limited in fibroid tumors.
(d) During vaginal operations, e.g. dilatation and curettage and repair of prolapse.
(e) To help correction of RVF by pulling backwards on the anterior lip of the crvix.
2. To grasp a prolapsed submucous myoma during a vaginal myomectomy.
3. During operation of hysterectomy it can be used to hold the cercal stump after the removal of the uterine body in subtotal hysterectomy.

Contraindications:
- ✓ The soft pregnant cervix,
- ✓ Infections,
- ✓ Suspicious malignancy of the cervix.

Complications:
- ✓ Lacerations of the cervix.
- ✓ Infections
- ✓ Bleeding from the site of the bite of the teeth of the vulsellum

Tenaculum

Double toothed vulsellum

Multiple toothed vulsellum

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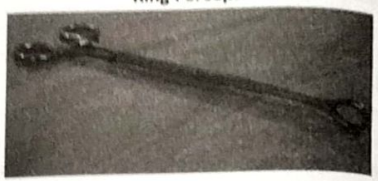
Ring and sponge forceps

Both posse a handle, a lock, a shank and 2 jaws at the tip, the jaws are either smooth or serrated, either rounded or oval in shape

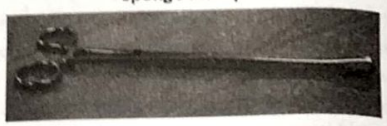
Indications:

1. To grasp the soft lips of the cervix in pregnancy, e.g. during evacuation
2. To evacuate a pregnant uterus per vagina
3. It is used for removing corporeal and cervical polypi.
4. Can be used as a sponge carrier

Ring Forceps



Sponge forceps

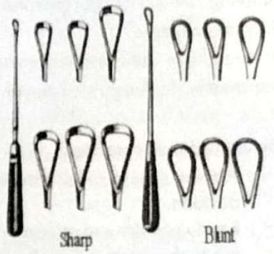


Ovum forceps

- ✓ It is a miniature of the obstetric forceps
- ✓ Each branch has a handle, a shank and a blade; the two branches are attached by a screw joint and has no lock
- ✓ It is used to remove an intact separated ovum; the cervix in these cases needs to be dilated to no 18 Hegar's and it is also used to evacuate the uterine content after D&C.

Single-ended corrugated sharp or blunt Uterine Curettes

- ✓ Each curette consists of 3 parts, the handle, the shank and the curetting end.
- ✓ The handle is corrugated on the aspect which corresponds to the direction of the bend at the tip. It can be either on the side (single-ended) or in the middle (double-ended).
- ✓ The shank is malleable & is hollow in the flushing variety to convey irrigating fluids which stimulates the uterus to contract and can also be used to deliver antiseptic material.
- ✓ The curetting end may be sharp or blunt, and some are spoon shaped.
- ✓ Some types have a curetting end on either tip (double-ended) with the handle in the middle.



I. Diagnostic curettage:

A) Bleeding

1. Dysfunctional uterine bleeding.
2. Symmetrically enlarged uterus.
3. Suspected uterine malignancy.
4. Secondary post-partum and post-abortive bleeding.
5. Cervical adenomatous polypi.
6. Doubtful extrauterine pregnancy to exclude the presence of chorionic vili.
7. Suspected TB and Bilharzia.

B) Amenorrhea

1. Atrophic endometrium.
2. Polycystic ovarian syndrome (Stein-Leventhal syndrome).
3. TB endometrium

C) Sterility

1. Anovulation.
2. TB endometrium.
3. Non-responsive endometrium.
4. Hormonal function of the ovaries

II. Therapeutic curettage:

1) For temporary or permanent cure of non-malignant uterine bleeding e.g. metropathia hemorrhagica and other types of functional bleeding and secondary post-partum and post-abortive bleeding.

2) Membranous dysmenorrhea.

3) Removal of endometrial polypi.

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4) In the management of some abortions (inevitable, incomplete, missed, cervical and therapeutic abortions) to ensure complete removal of the conceptus and decidua.
5) Vesicular mole.
6) To remove unhealthy endometrium during operation, e.g. Manchester (Fothergill's) operation and myomectomy.

The operation of curettage:

- ✓ Patient should be anesthetized and lying in the lithotomy position.
- ✓ Empty bladder and rectum.
- ✓ Dilate the cervix to No. 12 hegar's.
- ✓ The curette is introduced till the fundus and then by downward thrusts the endometrium is scraped systematically so that all walls is scraped, including the cornua and fundus.
- ✓ The curette of an area is considered complete when a gritty sensation is felt or heard.
- ✓ In cases of abortion and vesicular mole it is sometimes advisable to do curettage while an I.V. drip of syntocinon is continuously running to minimize the danger of proliferation.

Complications:

1. Sepsis: Introduction of infection into the uterine cavity leads to acute endometritis, salpingitis and /or peritonitis.
2. Perforation of the uterus: This is the most common complication occurring as a result of improper and too vigorous handling of the curette or aggravation of a minor laceration done by the dilator at the internal os. It is particularly liable to occur in malignant conditions, infections, vesicular mole and abortion.
3. Permanent amenorrhea and sterility result from vigorous over curettage removing the basal layer of the endometrium and intrauterine adhesions (Asherman's syndrome or Endometrial synechiae)
4. Excessive bleeding may occur during curettage in cases of carcinoma of the uterine body.
5. The use of a flushing curette may push endometrial tissue through the Fallopian tubes, leading to pelvic endometriosis or peritonitis.

Cervical Scrapers (wooden spatula) & Roller brush

For endocervical sampling

- ✓ This is a wooden spatula for "surface biopsy" which provides a
- ✓ selective cytology technique (pap smear).
- ✓ It is neither a true biopsy nor a smear, but a scraping from the
- ✓ squamo-columnar junction of the cervix.
- ✓ The irregularly shaped end of the scraper is used with its tip in the external os; with a rotatory movement the entire area of the squamo-columnar junction is scraped. The other end is used for scraping the surface of the edge of suspicious erosion.
- ✓ Pointed end for Nulliparous & other for multiparous
- ✓ It is diagnostic for Cervical cancer, caused by Human papilloma viruses (HPV)

Risk factors for cervical cancer:

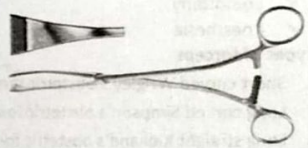
1. Old age.
2. White women.
3. Early sexual active.
4. Multiple sexual partners.
5. Smoking

Ayer's Cervical Scraper (wooden spatula)

Aylesbury's Cervical Scraper (wooden spatula)

Green Armytage forceps

- ✓ It is a long forceps with flattened serrated tips that serves as a holding and haemostatic instrument.
- ✓ It is usually used during the operation of lower uterine segment cesarean section to hold the flaps of the uterine incision to control bleeding from the edges and to help their suturing.



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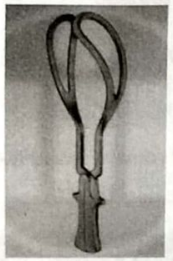

1. Long Curved Simpson's Obs Forceps

2. Short Curved Wrigley's Obs Forceps

3. Long Straight Kielland's Obs F

The Obstetric Forceps

Pre-requests:

- ✓ Cephalic presentation (piper forceps is used for breech)
- ✓ Head is engaged 0- 2
- ✓ Fully dilated bladder
- ✓ Maternal pelvis adequacy
- ✓ Ruptured membranes
- ✓ Empty bladder
- ✓ Episiotomy
- ✓ Anesthesia

Types of forceps

1. Short curved Wrigley's obstetric forceps.
2. Long curved Simpson's obstetric forceps
3. Long straight Kielland's obstetric forceps.

Types of forceps deliveries:

1. High forceps:

- ✓ This means forceps applied to a high head (non-engaged head).
- ✓ It is not done any more.

2. Mid-forceps

- ✓ The fetal head is engaged but the biparietal diameter is still above the ischial spine level.
- ✓ The lowest bony part of the head is felt below the ischial spines.

3. Low forceps (outlet forceps)

- ✓ The biggest transverse diameter (biparietal) has passed the ischial spine level.
- ✓ The lowest bony part of the head has already reached the perineum and is visible either during or between contractions.

Parts:

It consists of 2 branches, right and left. Each branch is made of:

1. A blade:
   - ✓ Each blade has a cephalic curve, a pelvic curve, and a fenestrum.
   - ✓ The cephalic curve: medial curved aspect of each blade.
   - ✓ The pelvic curve: This curve confirms with the curve of the birth canal.
   - ✓ The fenestrum makes the forceps lighter in weight, offers a firm grip over the head and avoids slipping and it minimizes injury of the head.
2. A shank: This is the part of the forceps intervening between the blade and the handles.
3. A handle: The handles cross to the opposite side of the blade so that the left handle is held by the left hand and is put at the left side of the birth canal and the right handle is held by the right hand and is put at the right side of the birth canal.
   - ✓ The branches are joined by a lock located at the junction between the shank and the handles
   - ✓ The left blade is inserted first followed by the right blade, because the lock will only locks if the right branch was placed on top of the left branch.

Direction of pull: Downwards, forwards

Types of forceps Application:

(A) Cephalic application:

- ✓ One blade on either side of the head along the mento-vertical diameter.
- ✓ The safety margin that is permissible extends from the zygoma anteriorly to the mastoid process posteriorly.

(B) Pelvic application

- ✓ The hand is applied inside the birth canal under the blade to prevent maternal tissue injury.
- ✓ The left blade is inserted first followed by the right blade.
- ✓ A safety margin within the pelvis extends from the sacroiliac joint to the iliopectineal eminence.

Kielland's Obstetric forceps:

- ✓ Long, straight (very slight) pelvic curve.
- ✓ It has a backward or a perineal curve on the posterior aspect.
- ✓ Overlapping shanks (upper and lower)
- ✓ A sliding lock allowing application to asynclitic heads.
- ✓ Light weight
- ✓ Main indication: rotation of the head and for application to asynclitic heads.
- ✓ Disadvantages: an unstable lock predisposes to cervical and vaginal lacerations

Action of the forceps:

1. Traction on the head (the main action).
2. Rotation of the head.
3. Compression of the head (this should be minimal to avoid intracranial hemorrhage).
4. Stimulation of uterine action.
5. Dilatation of the vulva.
6. One blade can be utilized to dislodge the head out of a lower segment cesarean section incision.

Indications of forceps delivery:

1. **Maternal**

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(A) Threatened dangers to the mother (prophylactic forceps):
- ✓ Toxemia of pregnancy (pre-eclampsia and eclampsia).
- ✓ Previous cesarean section
- ✓ Weakness in the abdominal wall (hernias and a history of a recent abdominal operation).
- ✓ Associated disease, e.g. Diabetes, heart disease, lung disease, chronic nephritis, hypertension, etc.

(B) Rigid pelvic floor and perineum

(C) Uterine inertia

(D) Maternal distress

2. Fetal

(A) Threatened dangers to the fetus (prophylactic forceps), as in the case of prolapse of a pulsating umbilical cord

(B) Abnormal presentations and positions: occipitoposterior, deep transverse arrest, face presentation, after-coming head.

(C) Large sized fetal head

(D) Fetal distress

3. Prolonged second stage of labor

(A) Over 1-2 hours in multiparae or 2-3 hours in primigravidae, depending on the uterine activity.

(B) When the head is on the perineum for one hour or more

Conditions to be fulfilled before forceps application (pre-requiites):

1. A deliverable cephalic presentation.
2. Engaged head
3. Empty bladder and rectum. (Dangers of a full bladder: genito-urinary fistula, rupture of the bladder, failed forceps, atonic post-partum hemorrhage, and stress incontinence).
4. Fully dilated cervix. Otherwise it might cause trauma to the cervix causing cervical tears or uterine prolapse (remote complication).
5. Use of anesthesia.
   - ✓ Allows proper application and extraction and avoids the development of obstetric shock.
   - ✓ It can be either: pudendal nerve block, low spinal or saddle block, epidural or general anesthesia.
6. Some uterine contractions must be present. Delivery with the obstetric forceps in the complete absence of contractions is followed by severe post-partum hemorrhage.
7. Ruptured membranes.
8. Episiotomy. Not always done, it is mostly indicated for primigravidae with rigid perineum

Complications:

(A) Fetal

1. Asphyxia (intracranial injury, aspiration, cord compression and anesthesia)
2. Fracture of the skull bones
3. Intracranial hemorrhage
4. Nerve lesions: Bell's pulsy, Brachial plexus injury.
5. Lacerations and contusions of the scalp and cephalhematoma which might get infected and forms an abscess.

(B) Maternal

1. Risks of anesthesia.
2. Traumatic lesions of the lower uterine segment, cervix, vagina and perineum.
3. Sepsis
4. Obstetric shock
5. Bone injuries:
   - ✓ Separation of the symphysis.
   - ✓ Dislocation of the sacro-iliac joint; this may be followed by a waddling gate, and severe low backache.
   - ✓ Fracture of the coccyx or its dislocation from the lower end of the sacrum.
6. Post-partum hemorrhage (traumatic, or atonic if delivery is completed in the absence of labour pains).
7. Vesico-vaginal fistula and stress incontinence. The former results either from direct trauma to a full bladder during application or extraction, or from ischemic effects of prolonged compression in protracted labor.

Forceps Operation in occipito-posterior and transverse positions:

1. Manual rotation

(A) Manual rotation of the head to bring the occiput anteriorly:
- ✓ This is done by the right hand for left positions and vice versa.
- ✓ The other hand is simultaneously placed on the abdomen to pull the back of the child towards the midline.
- ✓ It is followed by forceps delivery on the anteriorly rotated head.

(B) Manual rotation of the head to bring the occiput posteriorly:
- ✓ It is only done when attempts at anterior rotation fail.
- ✓ It is followed by forceps delivery as face to pubis.

2. Forceps rotation

(A) Scanzoni's double application maneuver:

It is done using the long curved obstetric curve as a rotator and an extractor.

After rotation of the head, the pelvic curve of the forceps will be directed backwards.

The forceps must be removed and reapplied with the pelvic curve of the instrument directed forwards.

(B) Kielland's forceps:

It is applied once with no need of reapplication because it is a long almost straight forceps.

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The Vacuum Extractor or Ventouse

Indications:

- ✓ All the indications of forceps delivery except the face (can cause serious eye damage) and after coming head. The ventouse is not helpful when a rapid delivery is aimed e.g. in fetal distress.
- ✓ To increase flexion in deflexed heads & to help forward rotation of the occiput in occipito posterior & deep transverse arrest.
- ✓ To assist completion of cervical dilatation; the cervix should be at least 3/4 dilated or more.
- ✓ It can be used to control bleeding by traction on the head in placenta previa.
- ✓ In cord prolapse it serves to prevent recurrence after its successful replacement
- ✓ It can be utilized to remove the head out of a lower uterine segment cesarean section
- ✓ It May be of help to correct inertia in the first stage by pulling the head to be well applied to the lower uterine segment & cervix.

Contraindication:

- ✓ Face, breech, & transverse presentation of the after coming head.
- ✓ Premature babies.
- ✓ Moderate or severe cephalo-pelvic disproportion.
- ✓ Fetal & maternal distress necessitating a rapid delivery.

Complications:

- ✓ Risk of cervical incompetence.
- ✓ Vaginal laceration from entrapment of vaginal mucosa between the suction cup and fetal head.
- ✓ Fetal skull injuries: cephalohematoma, intracranial hemorrhage & cerebral irritation, subaponeurotic hemorrhage and scalp lacerations, necrosis & alopecia.
- ✓ Longer delivery time.

Method:

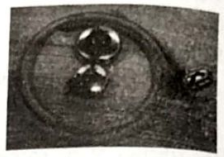
Use the largest possible cup.

Pressure is gradually reduced (in about 8 min.) to reach a max. Vacuum of 0.82 kg/cm (600 mmHg).

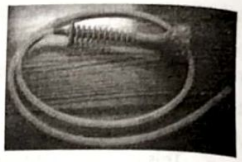
Allows the formation of a caput inside the cup to fill it.

It shouldn't be used for longer than 40 min (scalp necrosis &

Metal cup ventouse



Plastic cup ventouse Cervical



alopecia).

Advantage over the forceps:

Mother:

- ✓ Less risk of anesthesia, sepsis & trauma
- ✓ Helps cervical dilatation & +ve uterine contractions
- ✓ It doesn't occupy space adjacent to the fetal head → less trauma and smaller episiotomy.
- ✓ Can be applied if the cervix is not fully dilated.

Fetus:

- ✓ Corrects malattitudes of the fetal head
- ✓ Helps rotation of the head

Green Armytage forceps

Indication:

1.

2.

To rupture the amniotic membrane with minimal risk of trauma to foetus or mother.

Use for Amniotemy.

After the fetus is engaged and it has been determined that the patient is in true labour, then the membranes may be ruptured with the Amnihook.

Contraindication:

1. Cephalopelvic disproportion, unless slight, including the nullipara with a high head.
2. Abnormal presentation (with the possible exception of face or breech).
3. Unstable lie - risk of cord prolapse.
4. Foetal distress - caesarean section would be indicated.
5. Pplacenta praevia.
6. Cord presentation.
7. Vasa praevia.
8. Invasive carcinoma of the cervix.

For diagnosis rupture of membrane:

1. Nitrazine test: acts by pH and turn from yellow to blue in alkaline media. Blood, semen, urin & infection give false +ve test.
2. Ferning test: seen by microscope

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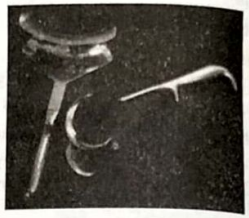
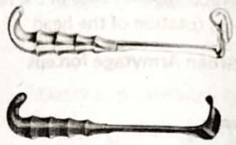
Doyn or doin retractor

To retract the Urinary Bladder



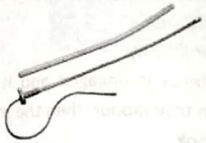
Skin Retractors

Retractor with weight



Fetal scalp electrode

Instrument used to monitor the baby's heartbeat while still in the uterus. This device is placed just under the skin of the baby's scalp.

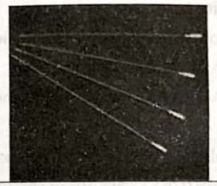


Pap smear kit

Which consist of spatula, fixative, slide & swab

Pipelle

For endometrial sampling. It works by suctioning i.e. –ve pressure



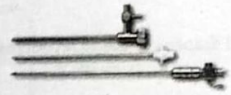
Veress needle & Laparoscope

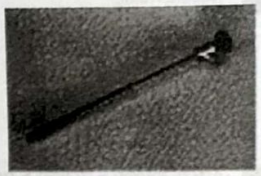
Indications:

1. To make the incision of laparoscopy
2. For Co2 inflation of the abdomen prior laparoscope
3. Laparoscope: diagnostic (infertility & ectopic pregnancy) & therapeutic (adhenolysis)

Complication:

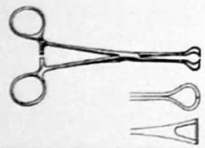
1. Pneumoperitoneum .
2. Injury to a hollow viscus.
3. Injury to vessels in the abdominal wall.
4. Damage to other organs.
5. Pelvic inflammatory disease.
6. Cervical laceration.
7. Uterine perforation
8. Shoulder pain.





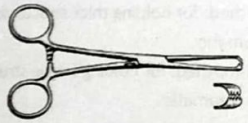
Babcock forceps

To hold a short length of intestine without compressing it



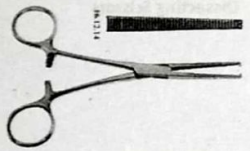
Allis forceps

Used to forcibly grasp or retract tissues or structures



Kocher forceps

For controlling bleeding in surgery, having serrated blades with interlocking teeth at the tips



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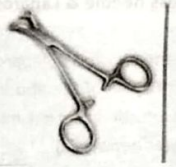
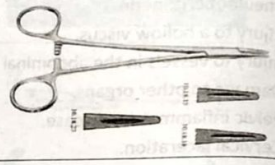
Towel clip

To hold drapes in place to retract tissue

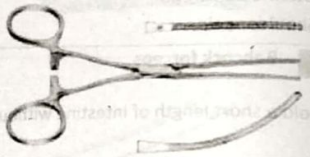


Needle Holder



Artery forceps – straight & curved

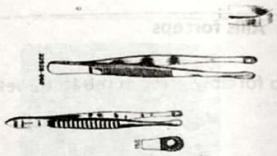
To clip the cord or a bleeding artery



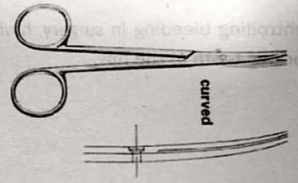
Tissue forceps

Toothed: for holding thick structures e.g. skin, it is traumatic

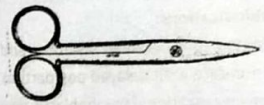
Not-toothed: for holding fragile structures e.g. vagina. It is less traumatic



Dissecting Scissors



Cutting Scissors



IUCD

Mechanism of action:

The primary mechanism of action of the IUD is spermicidal/ovicidal. It is prevent fertilization primarily by interfering with the ability of sperm to survive and to ascend the fallopian tubes, where fertilization occurs. Having a foreign body in the uterus, such as an IUD, causes both anatomical and biochemical changes that appear to be toxic to sperm. When a foreign body is in the uterus, the endometrium reacts by releasing white blood cells, enzymes and prostaglandins; and these reactions of the endometrium appear to prevent sperm from reaching the fallopian tubes. In addition, copper-bearing IUDs release copper ions into the fluids of the uterus and the fallopian tubes, enhancing the debilitating effect on sperm.

Side effects:

- ✓ Mood changes
- ✓ Acne
- ✓ Headaches
- ✓ Breast tenderness
- ✓ Pelvic pain
- ✓ Cramping (copper IUD)
- ✓ Increased bleeding during menstruation (copper IUD)
- ✓ Nausea

Advantages:

1. Allows sexual spontaneity.
2. Requires no daily attention.
3. Immediately effective.
4. Long-lasting.
5. Not messy.

Disadvantages:

1. Does not protect against sexually transmitted infections, including HIV/AIDS.
2. Insertion and removal require clinic visits.
3. Can be expelled.

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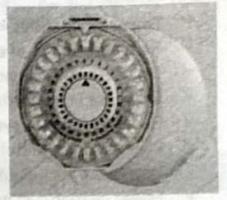
4. Can cause more difficult menstrual periods.
5. Possible risk to future fertility.

Contraindications:

1. Postpartum between 48 hours and 4 weeks (increased IUD expulsion rate with delayed postpartum insertion).
2. Benign gestational trophoblastic disease.
3. Ovarian cancer.
4. Very high individual likelihood of exposure to gonorrhea or chlamydial STIs.
5. AIDS (unless clinically well on anti-retroviral therapy).
6. Pregnancy.
7. Postpartum puerperal sepsis.
8. Immediately post-septic abortion.
9. Before evaluation of unexplained vaginal bleeding suspected of being a serious condition.
10. Malignant gestational trophoblastic disease.
11. Cervical cancer (awaiting treatment).
12. Endometrial cancer.
13. Distortions of the uterine cavity by uterine fibroids or anatomical abnormalities.
14. Current PID.
15. Current purulent cervicitis, chlamydial infection, or gonorrheal STIs.
16. Known pelvic tuberculosis.

Progestin-Only Contraceptives

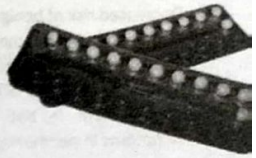


Mechanisms of action:

- ✓ Inhibition of ovulation
- ✓ Prevention of sperm penetration by thickening and decreasing the quantity of cervical mucus
- ✓ Endometrial atrophy

Advantages:

- ✓ No estrogen
- ✓ Reversible
- ✓ Amenorrhea or scanty bleeding
- ✓ Improvement in dysmenorrhea, menorrhagia, PMS, endometriosis symptoms
- ✓ Decreased risk of endometrial or ovarian cancer
- ✓ Decreased risk of PID
- ✓ Compatible with breast-feeding
- ✓ Best choice for Cardiac Pt.



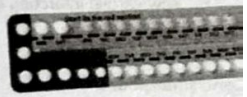
Disadvantages:

- ✓ Menstrual cycle disturbances
- ✓ Weight gain
- ✓ Depression
- ✓ Lack of protection against STIs

Contraindications:

1. Known or suspected pregnancy
2. Unexplained vaginal bleeding
3. Breast cancer
4. Medication that cause progestins to be metabolized more rapidly:
   - ✓ Anti-seizure medications: phenytoin, phenobarbital, carbamazepine, primidone, phenlbutazone, and
   - ✓ Antibiotics: rifampin/rifampicine
5. Active thrombophlebitis or pulmonary emboli

Combination Contraceptives (Estrogen & Progestin)



Mechanisms of action:

- ✓ Suppression of ovulation
- ✓ Thickening of cervical mucus
- ✓ Thinning of endometrium
- ✓ Slowing of tubal and endometrial motility

Advantages:

- ✓ Highly effective in preventing pregnancy when taken correctly
- ✓ Not related to coitus
- ✓ Rapid return to fertility after discontinuation
- ✓ Very safe when prescribed for appropriate users
- ✓ Can be used throughout the reproductive years

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Health benefit:

- ✓ Fewer pregnancies = fewer maternal deaths
- ✓ Reduction in risk of ectopic pregnancy
- ✓ Decrease in dysmenorrhea
- ✓ Decrease in menorrhagia
- ✓ Reduction in PMS symptoms
- ✓ Elimination of Mittelschmerz
- ✓ Decreased anovulatory bleeding
- ✓ Fewer ovarian cyst problems
- ✓ Endometrial and ovarian cancer risk reduction
- ✓ Decreased risk of benign breast conditions
- ✓ Suppression of endometriosis
- ✓ Improvement of androgen-sensitivity or androgen-excess conditions (such as PCOS)
- ✓ Improvement in hot flashes and hormonal fluctuation symptoms in perimenopausal women

Disadvantages:

- ✓ Must be taken consistently and correctly to be effective
- ✓ Storage, access, lack of privacy
- ✓ Can interfere with lactation
- ✓ No protection against STIs
- ✓ Common side effects include:
  - Breast tenderness
  - Decrease libido
  - Skin hyper pigmentation
  - Nausea & Vomiting
  - Headache
  - Weight gain

Complications:

- ✓ Venous thromboembolism.
- ✓ Myocardial infarction and stroke.
- ✓ Hypertension.

Contraindications:

- ✓ Personal history of thrombosis; known clotting disorder (factor V Leiden mutation, etc.).
- ✓ Personal history of stroke or MI.
- ✓ Labile hypertension.
- ✓ Estrogen-sensitive malignancy (such as breast CA).
- ✓ Active liver disease.
- ✓ Migraines with focal neurologic symptoms.

Unit 10

SECRETS OF SURGERY

HIGH YIELD

Question 1

a. What is the name of this investigation?
b. Write positive findings?
c. Write emergency management steps?
d. Write definite management?

Answer:

a. Radiograph of the radius and ulna AP view
b. Fracture of radius and ulna
c. Follow A,B,C,D and analgesia, internal fixation with DCP for radius and ulna

Question 2

A 43 yrs old labourer fell from the height and has a wound of 8 x 6 in size over the middle of right shin leading to exposed bone.

a. What is possible injury?
b. Write most appropriate treatment?
c. Write 3 complications of this injury

Answer:

a. Fracture of tibia and fibula
b. Follow ATLS guide lines, antibiotics, analgesics, tetanus prophylaxis, meticuolous debridment of this wound, fracture site curettage and external fixation
c. Non-union, infection, neuro-vascular injury, associated abdominal and chest injuries

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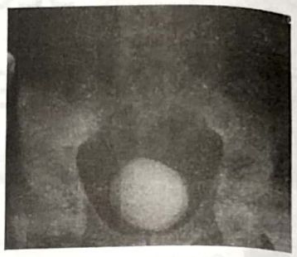
Question 3

a. Write investigation name?
b. Write findings?
c. Write 3 complications of disease?
d. Write 2 treatment options?

Answer:

a. X Ray abdomen KUB
b. A radio opaque shadow in urinary bladder area (vesicolithiasis)
c. i. Urinary retention
ii. Hematuria
iii. Urinary tract infection
d. Open vesicolithotomy, Percutaneous Lithopaxy

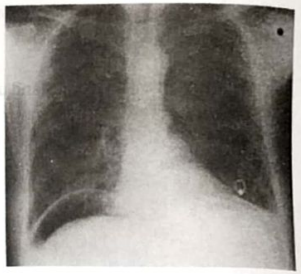


Question 4

a. What is the finding in this x ray?
b. Write 2 causes?
c. How will you manage this patient?

Answer:

a. Air under Diaphragm
b. i. Perforated duodenal ulcer
ii. Perforation of ilium due to typhoid or tuberculosis
c. i. Resuscitation: intravenous fluids, antibiotics, analgesics, Foley Catheterization, nasogastric aspiration, investigations
ii. Open or laparoscopic repair



Question 5

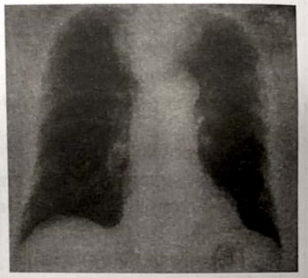
A 55 yrs old female patient with a large swelling in front of neck.

a. What is probable diagnosis?
b. Name a life threatening complication that it can cause?
c. What other investigations??
d. Write treatment?

Answer:

a. Retrosternal goiter
b. Tracheal compression, respiratory obstruction
c.
- ✓ TSH, free T3 and T4
- ✓ Thyroid scan
- ✓ Thyroid autoantibodies

d. Total or subtotal thyroidectomy

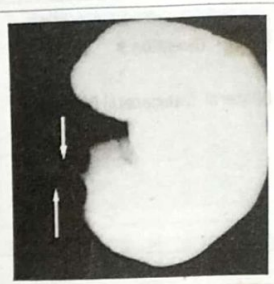


Question 6

a. What is your diagnosis?
b. Other imp investigation to be done?
c. If it is a malignant condition, write One operative treatment which Should be done.

Answer:

a. Pyloric stenosis
b. Gastroscopy
c. Radical gastrectomy



Question 7

This patient presented with dysphagia and recurrent chest infection.

a. Identify investigation?
b. Write findings?
c. Write differential diagnosis?

Answer:

a. Barium Swallow
b. Narrowing at the lower end of esophagus and dilated Proximal esophagus
c. i. Carcinoma esophagus
ii. Cardia achlasia
iii. Esophageal Stricture

Question 8

Anterior dislocation Of shoulder Joint

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Question 9

Bilateral Interfacetal Dislocation

Question 10

Cervical rib

Question 11

Dislocation of hip

Question 12

Distal radius Fracture

Question 13

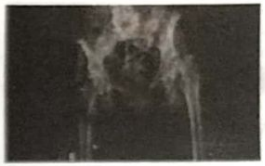
ERCP

Question 14

Faecolith causing Large bowel Obstruction

Question 15

Femoral neck Fracture AP pelvis X ray



Question 16

Fracture of Patella

Question 17

Hydropneumothorax

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Question 18

Kidney Stones

Question 19

MRCP

Question 20

PTC

Question 21

Right lung Hemothorax

Question 22

Urethral Stricture

Question 23

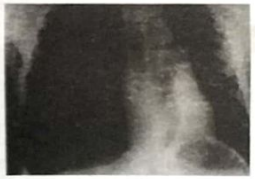
Supracondylar fracture of humerus

Question 24

T-tube Cholangiogram

Question 25

Tension Pneumothorax



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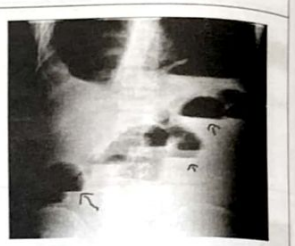
Question 26

Bowel Obstruction

Question 27

X ray with air fluid levels, intestinal obstruction

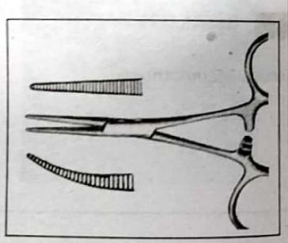


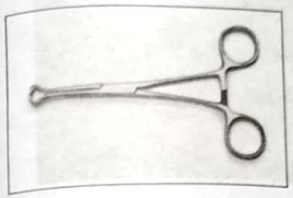
Question 28

Allis tissue forceps

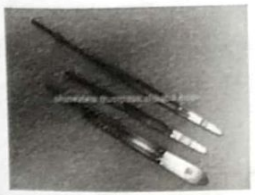
Question 29

Artery forceps

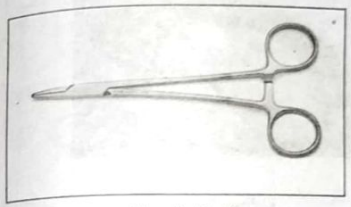




Bacock's tissue forceps



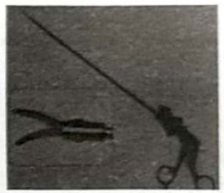
Bard Parker knife handle



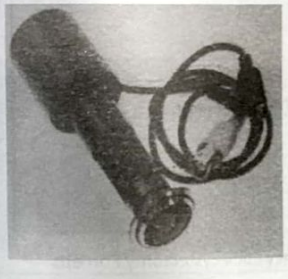
Needle Holder

Tooth forceps

Towel Clip



Laparoscopy Scissor



Laparoscopy camera

Bulldog atraumatic clamps

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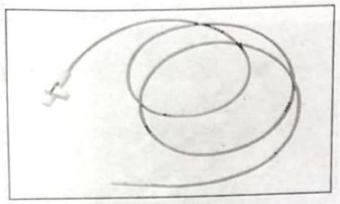
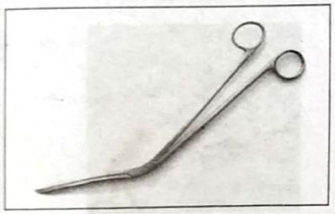


Fogarty Catheter

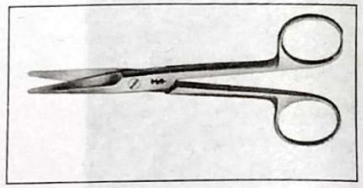
Desjardin's Forceps

Proctoscope

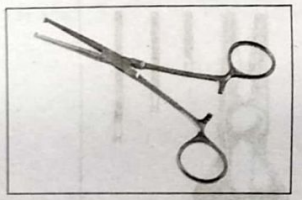
Kidney Tray



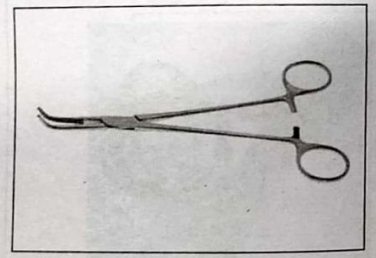
Cheatle's Forceps



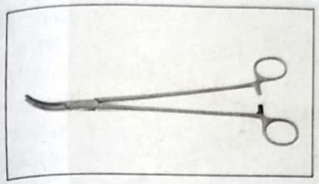
Suture cutting scissor (Straight scissor)



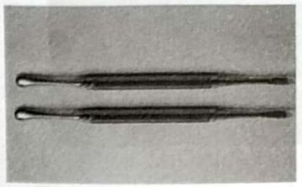
Kocher's Forceps



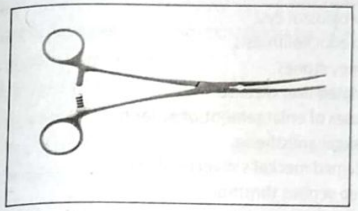
Lahey Cholecystectomy Forceps



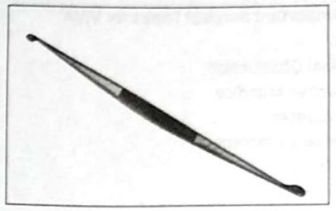
Moynihan Cholecystectomy Forceps



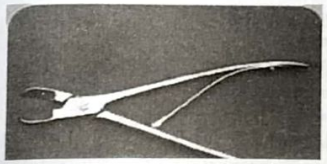
Molt periosteal levator



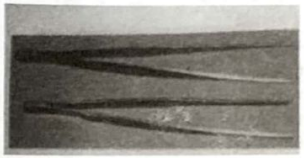
Curved Doyen Intestinal forceps



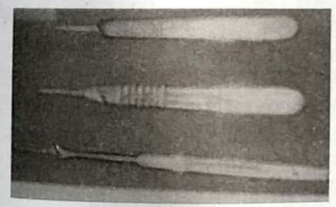
Currette



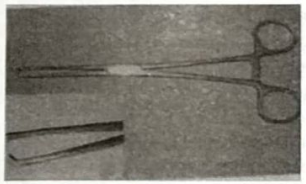
Single Action Bone CUtter



Plain forceps and tooth forceps



Bard Parker knife handle



Allis tissue holding forceps

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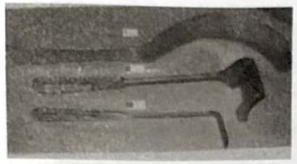
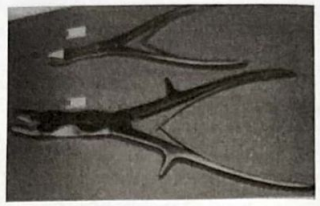


i.Deaver's retractor
ii.Morris retractor
iii.Langenbeck's retractor



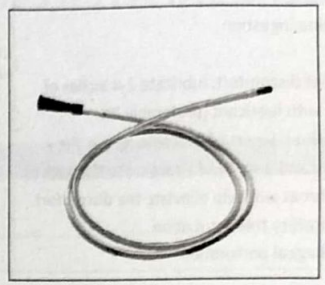
Bone Cutter and Bone Nibbler

Important Surgical Topics for VIVA

1. Goiter
2. Intestinal Obstruction
3. Obstructive Jaundice
4. Breast Cancer
5. Colorectal carcinoma
6. Appendicitis
7. Cholelithiasis
8. Mass abdomen
9. Mass right iliac fossa
10. Dysphagia
11. Pain right iliac fossa
12. Inguinal hernia
13. Hydrocele
14. Paraumbilical and Incisional hernia
15. Varicose veins
16. Examination of breast
17. Examination of lymph nodes
18. Examination of peripheral nerves
19. Examination of thyroid
20. Examination of Ulcer
21. Examination of Neck Swelling
22. Examination of abdomen
23. Varicocele
24. Sebaceous Cyst
25. Lipoma
26. Fractures
27. Subdural hematoma
28. Acute pancreatitis
29. Testicular mass
30. Cystic hygroma
31. Thyroglossal cyst
32. Choledocholithiasis
33. Kidney stones
34. Hydated liver disease
35. Causes of enlargement of spleen
36. General anesthesia
37. Inflamed meckel's diverticulum
38. Deep venous thrombosis
39. Prolapsed thrombosed haemorrhoides
40. Diabetic foot
41. Gas gangrene post traumatic
42. Anal fissure
43. Burns
44. Perforated Ulcer
45. Gall bladder cancer
46. Mammary duct fistula
47. Multinodular Goiter
48. Gastric Carcinoma
49. Pleomorphic adenoma
50. Perianal abscess/fistula

Question 2

a. Identify item
b. Write its indications.
c. How will you confirm its position?
d. What are contraindications?
e. What are the complications?



Answer:

a. Nasogastric tube

b. i. To decompress the gastrointestinal tract in case of intestinal obstruction and in paralytic ileus
ii. Gastric lavage in organophosphorus poisoning and gastric hemorrhage
iii. it is used to feed unconsciousness patient or who is unable to take orally

c. The position of the tip can be made out easily by one of the following ways.

- ✓ Inject few CC of air into the tube and at the same time auscultate over the epigastrium, gurgling sound (whoost test) will be heard if tube is in the stomach
- ✓ Aspirate the gastric contents: if the tube is in the stomach then gastric contents comes out freely PH testing can be performed for confirmation of gastric contents
- ✓ A radiograph must be taken to locate the exact position of the tip of the tube
- ✓ After confirmation of the position of the tube apply drainage bag and secure the tube by adhesive tape with the nostril

d. **Absolute contraindications:**

- ✓ Nasogastric tubes are contraindicated in the presence of severe facial trauma (cribriform plate disruption), due to the possibility of inserting the tube intracranially. In these situations, an orogastric tube may be inserted.
- ✓ Recent nasal surgery

Relative Contraindications:

- ✓ Coagulation abnormality
- ✓ Esophageal varices or stricture
- ✓ Recent banding or cautery of esophageal

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varices
- ✓ Alkaline ingestion

e.
- ✓ Patient discomfort: lubricate 2-4 inches of tube with lubricant (preferably 2% lidocaine). Squirt of lidocaine jelly in the nostril and a spray of lidocaine to the back of the throat will help alleviate the discomfort.
- ✓ Respiratory tree intubation
- ✓ Esophageal perforation

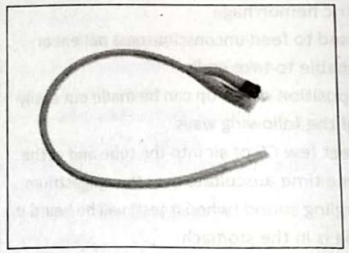
Question 3

a. Identify the object.
b. Write 2 indications?
c. Write 2 complications of its use?

Answer:

a. Two way Foley catheter

b.
- ✓ Bladder out flow obstruction
- ✓ For measurement of urine output
- ✓ In critically ill patient
- ✓ After TURP
- ✓ Haemorrhage, infection



Question 3

What are complications of Spinal Anesthesia?

Answer:

i. Hypotension
ii. Post-spinal headache
iii. Meningitis
iv. Urinary Retention
v. Bradycardia and cardiac arrest
vi. Injury to nerve roots and spinal cord

Unit 11

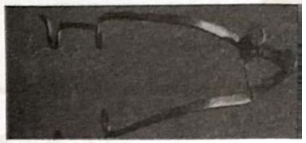
SECRETS OF OPHTHALMOLOGY HIGH YIELD

Question 1

a. Identify the instrument.
b. Write uses?

Answer:

a. Eye speculum with screw (it has two limbs with a screw to adjust the limbs)
b. Eye speculum are used to keep the lids apart during surgical procedures such as cataract, glaucoma, squint, pterygium and removal of foreign body from conjunctive and cornea.

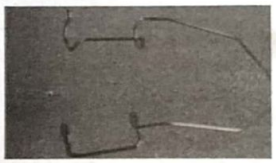


Question 2

a. Identify the instrument.

Answer:

Wire speculum



Question 3

a. Identify the instrument.
b. Write uses?

Answer:

a. Plain forceps (it is simple forceps without any teeth)
b. To hold the tissues during operation such as conjunctiva, sclera flap in trabeculectomy, skin during eyelid surgery and nasal mucosal flaps and lacrimal sac flaps in DCR operation.

Question 4

a. Identify the instrument.
b. Write uses?

Answer:

a. Fixation forceps
(it has narrow or wide jaws. It has 2 x 3 or 3 x 4 teeth at the tip)
b. To fix eyeball during the operation on the eyeball and to hold eyeball during forced duction test.

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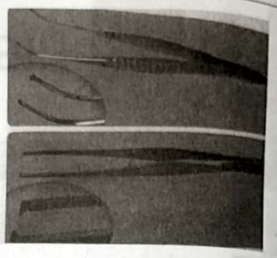
Question 5

a. Identify the instrument.
b. Write uses?

Answer:

a. Superior rectus holding Forceps (it is a tooth Forceps with 1x2 teeth)
b. To hold the superior rectus Muscle while passing a bridle suture under the superior rectus muscle.



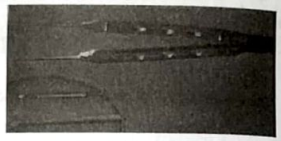
Question 6

a. Identify the instrument.
b. Write uses?

Answer:

a. Corneal forceps (The forceps has very fine teeth (1x2) at the tip

To hold the corneal or scleral edge (of incision) for suturing during cataract, glaucoma, repair of corneal and or sclera tears and keratoplasty operations.



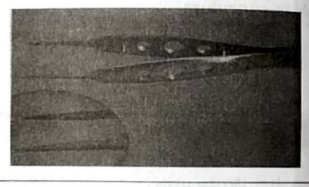
Question 7

a. Identify the instrument.
b. Write uses?

Answer:

a. Suture tying forceps (The forceps has very fine plain tips)

To hold the suture during suturing for cataract, glaucoma, repair of corneal and/or sclera tears and keratoplasty operations.

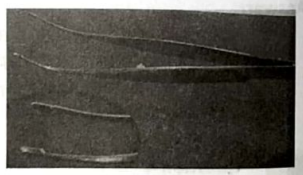


Question 8

a. Identify the instrument.
b. Write uses?

Answer:

a. Arruga's intracapsular (capsule holding) forceps (it has a cup on the inner side of the tip of each limb)
b. It is used to hold the lens capsule to remove the lens in intracapsular cataract extraction.



Question 9

a. Identify the instrument.
b. Write uses?

Answer:

a. Epilation forceps (it has blunt and flat ends)

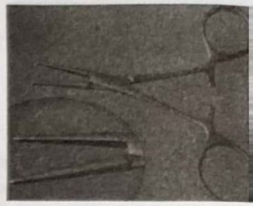
To epilate the cilia in trichiasis and stye

Question 10

a. Identify the instrument.
b. Write uses?

Answer:

a. Artery (haemostatic) forceps (it is the multiple straight groves (at right angle to the limbs) near the tip and a locking mechanism near the ringed end. These can be straight or with curved ends.
b. To catch bleeding vessels during the operations of the lids and lacrimal sac and to hold skin and muscle stay sutures.



Question 11

a. Identify the instrument.
b. Write uses?

Answer:

a. Lens expressor (hook). It has a flat medal handle with rounded curve at one end. Tip of the curve is knobbed.
b. To apply pressure on the limbus at 6 o clock position during the delivery of lens in intracapsular cataract extraction and to express the nucleus in extracapsular cataract extraction. It can also be used as a muscle hook.

Question 12

a. Identify the instrument.
b. Write uses?

Answer:

a. Muscle (strabismus) hook. It is similar to the lens expressor in appearance but has a blunt guarding knob at the end to prevent muscle slippage.
b. To engage the extraocular muscles during squint surgery, enucleation and retinal detachment. It can also be used as lens expressor.

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Question 13

a. Identify the instrument.
b. Write uses?

Answer:

a. Desmarre's retractor (it is a saddle shaped instrument folded on itself at one end)
b. To retract the lids during examination of the eyeball in case of blephasrospasm in children, in cases with marked swelling and ecchymosis.

Question 14

a. Identify the instrument.
b. Write uses?

Answer:

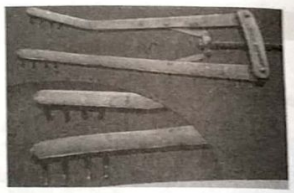
a. Cat's paw lacrimal wound retractor
(it is fork-like with terminals bent inward)
b. To retract the skin during lacrimal sac and lid surgery

Question 15

a. Identify the instrument.
b. Write uses?

Answer:

a. Self-retaining lacrimal Wound (Muller's) retractor.
(it is made up of two limbs with three curved pins on each engaging the edges of incision. The limbs are kept in retracted position with the help of a fixation screw)
b. To retract the skin during lacrimal sac surgery



Question 16

a. Identify the instrument.
b. Write uses?

Answer:

a. Spring action (Barraquer's Type) needle holders
(The jaws of needle holder are firmly serrated to hold the fine needles firmly)
b. For passing sutures in conjunctive, cornea, sclera and extraocular muscles

Question 17

a. Identify the instrument.
b. Write uses?

Answer:

a. Castroviejo's needle holder
(it is a medium-sized spring action needle holder)
b. It is generally used extraocular surgery such as conjunctival suturing and squint surgery and also for intraocular surgery.

Question 18

a. Identify the instrument.
b. Write uses?

Answer:

a. Arruga's Steven, Silcock's and Kelt needle holder
(it is a large needle holder with and without locking device)
b. Very commonly used in lid surgery and for passing superior rectus suture

Question 19

a. Identify the instrument.
b. Write uses?

Answer:

a. Keratomes (it has a thin diamond shape blade with a sharp apex and two cutting edges. Straight as well as curved keratomes are available in various sizes (2.8 mm, 3 mm, 3.5 mm and 5.5 mm)
b. To make the valvular corneal incision for entry into the anterior chamber for all modern techniques of cataract surgery e.g phacoemulsification and conventional ECCE.

Question 20

a. Identify the instrument.
b. Write uses?

Answer:

a. 15 (degree) side port entry blade (it is a fine straight knife with a sharp pointed tip and cutting edge on one side)
b. To make a small valvular clear corneal incision (commonly called as side port incision) in phacoemulsification. It is also used for paracentesis.

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Question 21

a. Identify the instrument.
b. Write uses?

Answer:

a. Crescent knife
(it is a sharp curved, bevel up knife having cut splitting action at the tip and both the sides)
b. To make tunnel incision in sclera and cornea for phacoemulsification and manual small incisions cataract surgery.

Question 22

a. Identify the instrument.
b. Write uses?

Answer:

a. Tooke's knife
(it has a short flat blade with a semicircular blunt dissecting the edge)
b. It is used to separate the conjunctiva and subconjunctival tissue from the sclera and limbus, to separate partial thickness lamella of sclera during trabeculectomy and to separate corneal lamella in lamellar keratoplasty.

Question 23

a. Identify the instrument.
b. Write uses?

Answer:

a. Cytotome or capsulotome
(it is a small needle knife with bent tip, which is sharp on both the edges. Disposable cytotome is preparaed by bending the tip of disposable 26 gauge or 30 gauge hypodermic needle at 90 degree and shaft at 45 degree)
b. For doing anterior capsulotomy or capsulorhexis during extracapsular cataract extraction.

Question 24

a. Identify the instrument.
b. Write uses?

Answer:

a. Foreign body spud
(it has small, stout and flat blade with blunt tip and edges on both sides)
b. To remove the corneal foreign body

Question 25

a. Identify the instrument.
b. Write uses?

Answer:

a. Plain straight scissors
(it is a fine pointed scissor
With straight sharp cutting blades)
b. It is used to cut conjunctival sutures, eyelashes and muscles

Question 26

a. Identify the instrument.
b. Write uses?

Answer:

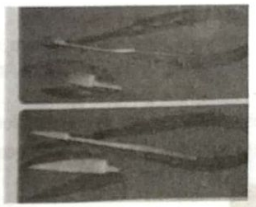
a. Plain curved scissors
(it is a plainwith curved
Sharp cutting blades)
b. To cut and undermine conjunctiva and skin in various operations

Question 27

a. Identify the instrument.
b. Write uses?

Answer:

a. Corneal scissors or section Enlarging scissors
(Their cutting blades are
Kept apart by spring action)
b. To enlarge the corneal or sclerocorneal incision in cataract surgery



Question 28

a. Identify the instrument.
b. Write uses?

Answer:

a. De Wecker's Scissors
(They are fine scissors with small blades directed at right angles to the arms)
b. To perform iridectomy for cutting a prolapsed formed vitreous

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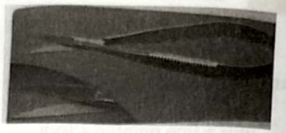
Question 29

a. Identify the instrument.
b. Write uses?

Answer:

a. Spring scissors (Westcott's)
b. It is used for cutting and undermining conjunctiva in various operations and cut sutures.

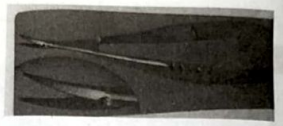


Question 30

a. Identify the instrument.
b. Write uses?

Answer:

a. Vannas scissors
(It is fine delicate pair of scissors with sharp edges)
b. It is used to cut vitreous during a prolapsed vitreous

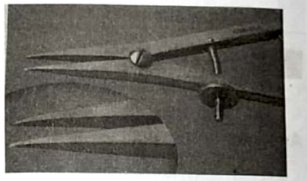


Question 31

a. Identify the instrument.
b. Write uses?

Answer:

a. Castroviejo caliper
(It is a divider-like instrument, to one arm of which is attached a graduated scale (in mm). its other arm can be moved by a screw over the scale.
It is used to take measurement during squint, ptosis, retinal detachment and pars plana vitrectomy surgery.



Question 32

a. Identify the instrument.
b. Write uses?
c. Name the commonest clinical condition for which this instrument is used?
d. Indicate which side of the instrument, open or the metallic flat side faces the skin of the lids during the surgery.

Answer:

a. Chalazion clamp
(It consists of two limb like forceps, which can be clamped with the help of screw)
b. To fix chalazion and achieve haemostasis during incision and drainage
c. Chalazion
d. Flat metallic side

Question 33

a. Identify the instrument.

Answer:

a. Ptosis clamp
It consists of D-shaped plate opposed by U-shaped rim, which can be tightened by the help of screw, clamp the tissue. The plate is toward the conjunctival side so it protects the eye during lid surgery on the skin side. The screw faces the outer side and the handle is always situated on the temporal side.

Question 34

a. Identify the instrument.
b. Write uses?

Answer:

a. Entropion clamp
(It has plate which is placed under the eyelid, a curved hook, which will be on the outer side of the lid and screw to tight the lid.
b. It is used for entropion surgery to hold the eyelid and create the haemostasis

Question 35

a. Identify the instrument.
b. Write uses?

Answer:

a. Blade braker
(It has a handle and two blades to fix the part of blade)
b. It is used to fix the part of atom blade which is used during cataract for corneal incision

Question 36

a. Identify the instrument.
b. Write uses?

Answer:

a. Wire vectis
(It is a circular, oval structure attached to a metallic handle)
b. It is used to remove dislocated or subluxated lens and nucleus in ECCE.

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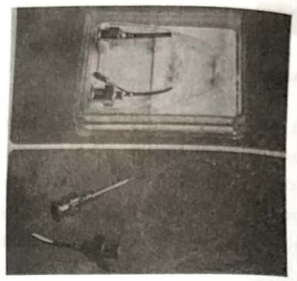
Question 37

a. Identify the instrument.
b. Write uses?

Answer:

a. Two-way irrigation and Aspiration cannula
(It is available in various Designs, commonly used are Simcoe, classical or reserve Cannula)
b. For irrigation and suction of lens matter in extracapsular cataract extraction, aspiration of hyphaema.

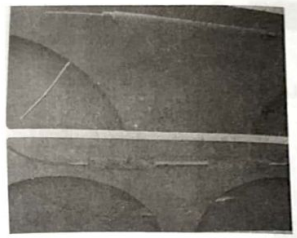


Question 38

a. Identify the instrument.
b. Write uses?

Answer:

a. Iris repositor
(It is a delicate, flat, metallic Straight or bent blade with blunt edges and tip attached to a handle)
b. To reposit the iris in the anterior chamber in any intraocular surgery



Question 39

a. Identify the instrument.
b. Write uses?

Answer:

a. Kelman McPherson forceps
(IOL holding forceps)
b. To hold the haptics of IOL during its placement

Question 40

a. Identify the instrument.
b. Write uses?

Answer:

a. Sinskey hook or IOL dialer
(It is a fine instrument with a bent tip, which engages the dialing hole of the IOL)
b. To dial the IOL for proper positioning in the capsular bag

Question 41

a. Identify the instrument.
b. Write uses?

Answer:

a. Hydrodissection cannula
(It is a single bore 25G, 27G or 30G cannula with 45 degress angulation at about 10-12 mm from the free end)
b. To perform hydrodissection (separation of posterior capsule from the cortex) and hydrodelineation (separation of cortex from the nucleus) in phacoemulsification.

Question 42

a. Identify the instrument.
b. Write uses?

Answer:

a. Chopper
(it is a fine instrument, resembling a hook in shape. The inner edge of the bent tip is used as the cutting edge)
b. It is used to split or chop the nucleus into smaller pieces

Question 43

a. Identify the instrument.
b. Write uses?

Answer:

a. Chalazion scoop
(It is a small cup with sharp margins attached to a narrow blade)
b. To scoop out the contents of chalazion during incision and curettage

Question 44

a. Identify the instrument.
b. Write uses?

Answer:

a. Punctum dilator (Nettleship's)
(it is a cylindrical corrugated metal handle with conical pointed tip)
b. To dilate the punctum and canaliculus during syringing, probing and DCR operation

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Question 45

a. Identify the instrument.
b. Write uses?

Answer:

a. Lacrimal Probes (Bowman's)
(These are sets of staright metal wires of varying thickness, with blunt rounded end and flattened central part
b. To probe nasolacrimal duct in congenital bloackage and DCR operation

Question 46

a. Identify the instrument.
b. Write uses?

Answer:

a. Lacrimal Cannula
(it is a ling curved hypodermic needle with blunt tip)
b. For syringing the lacrimal passages

Question 47

a. Identify the instrument.
b. Write uses?

Answer:

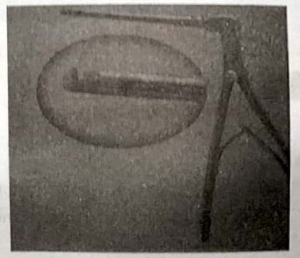
a. Lacrimal Cannula
(it is a ling curved hypodermic needle with blunt tip)
b. For syringing the lacrimal passages

Question 48

a. Identify the instrument.
b. Write uses?

Answer:

a. Bone Punch
(it has a spring handle with two blades)
b. To enlarge the boney opening during DCR operation



Question 49

a. Identify the instrument.
b. Write uses?

Answer:

a. Dacryocystorhinoostomy (DCR) Burr
(it has a handle at one end serrated burr at the other end)
b. It is used to create a hole in the lateral wall of nose

Question 50

a. Identify the instrument.
b. Write uses?

Answer:

a. Bone nibbler
b. It is used to break the bone and enlarge the hole created by DCR burr

Question 51

a. Identify the instrument.
b. Write uses?

Answer:

a. Evisceration spatula
(it consists of a small rectangular blade with slide convex surface and blunt edges attached to the handle)
b. It is used to separate the uveal tissue in evisceration operation

Question 52

a. Identify the instrument.
b. Write uses?

Answer:

a. Direct Ophthalmoscope
b. It used for distant direct ophthalmoscopy and fundus examination

Question 53

a. Identify the instrument.
b. Write uses?

Answer:

a. Applanation Tonometer
b. It used to measure the intraocular pressure

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Question 54

Write 5 differential diagnosis of red eye?

Answer:

- ✓ Conjunctivitis
- ✓ Keratitis
- ✓ Acute congestive glaucoma
- ✓ Episcleritis
- ✓ Scleritis
- ✓ Subconjunctival haemorrhage
- ✓ Corneal foreign body
- ✓ Endophthalmitis
- ✓ Panophthalmitis

Question 55

a. Write Infective Causes of corneal ulcer?
b. Write name of Contraindicated drug for infected corneal ulcer?

Answer:

a. i. Bacteria: gram-positive and gram negative organism
ii. Protozoa: Acanthaamoeba spp
iii. Virus: Herpes simplex and Herpes Zoster virus
iv. Fungi: Aspergillus fumigates and candida albicans
v. Chlamydia Trachomatis
b. Corticosteroids

Unit 12

HIGH YIELD DERMATOLOGY

TOP SECRETS DERMATOLOGY

1. Severe acne is more common in men than in women due to higher levels of circulating androgens.
2. **Rosacea**• A chronic condition resulting in reddening of the face (mainly the forehead, nose, and cheeks). It often appears very similar to acne, but unlike acne it first starts in middle age.
3. **Keratoacanthoma**• Epithelial tumors which clinically resemble squamous cell carcinoma (SCC).
4. **Tinea Versicolor**• A common superfcial fungal infection which is likely caused by several species in the Malassezia group, which are part of the normal skin flora
5. stuck on appearance →seborrheic keratosis
6. Seborrheic dermatitis is a chronic condition with no cure. Therapy may be needed indefinitely for control of symptoms.
7. Cradle cap →seborrheic dermatitis.Treat conservatively with bathing and moisturing agents
8. Atopic dermatitis—onset is in infancy or childhood
9. Erythema multiforme (EM) is an inflammatory skin condition characterized by erythematous macules/papules that resemble target lesions **("bull's-eye lesions")** that can become bullous.
10. **Lichen Planus** (P disease):planar, **p**ruritic, **p**olygonal, persistent, penile, perioral, **p**urple, flat-topped **p**apules.
11. A premalignant lesion from sun exposure that can lead to squamous cell carcinoma →Actinic keratosis
12. Four characteristics of a nevus suggestive of melanoma→asymmetry, border irregularity, color variation and large diameter.
13. Warts are caused by HPV and are transmitted via skin-to-skin contact. For genital warts, transmission is via intimate sexual contact.
14. **Molluscum Contagiosum**
    • A common, self-limited viral infection caused by a **poxvirus;** common in sexually active young adults and in children.
15. Warts can be recurrent and may require multiple treatments (despite the method of therapy chosen.
16. Dermatophytes are superfcial fungi that infect cutaneous epithelium, nails, and hair.

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17. Treat tinea capitis and onychomycosis with oral antifungal agents. Others are treated with topical antifungals.
18. Scabies Caused by the human skin mite Sarcoptes scabiei var hominis.
19. **Actinic Keratosis** (Also Called Solar Keratosis)
    • Small, rough, scaly lesions due to prolonged and repeated sun exposure.
20. **Pinkish, scaling, flat lesions on the chest and back; KOH prep has a (spaghetti and meatballs)appearance. →tinea (pityriasis)versicolor.**
21. **Basal cell carcinoma (BCC) is the most common skin cancer** (accounts for 60% to 75% of all skin cancers).
22. SCC is less common than BCC
23. **Marjolin ulcer:** a SCC arising from a chronic wound such as a previous burn scar (tends to be very aggressive).
24. Women with malignant melanoma have a better prognosis than men (with equivalent lesions).
25. Presents with herald patch, Christmas tree pattern →pityriasis rosea.
26. Melanoma Most aggressive form of skin cancer and **the number one cause of death due to skin cancer.**
27. **Iris like target lesions→Erythema multiforme.**
28. **Seborrheic Keratosis•** These are very common skin lesions that begin to appear after age 30. Hereditary—they probably are autosomal dominant and are harmless growths with no malignant potential.
29. **Flat topped papules. →Lichen planus.**
30. Dermatomal distribution→varicella zoster.
31. Nikolsky's sign positive →Pemphigus vulgaris
32. Nikolsky's sign Negative→Bullous pemphigoid
33. Honey crusted lesions→impetigo
34. Urticaria is caused by the release of mediators from mast cells, with a resultant increase in vascular permeability.
35. **Angioedema**
    • The mechanism is similar to that in urticaria, though angioedema occurs deeper in the skin (i.e., fluid extravasation occurs in deeper layers of skin/subcutaneous tissue). Angioedema and urticaria can occur simultaneously or independently.
36. **Types of Hypersensitivity Reactions**
    • **type i:** IgE-mediated (e.g., anaphylaxis, asthma)
    • **type ii:** IgG- (or IgM-) and cytotoxic cell-mediated (e.g., Goodpasture disease, pemphigus vulgaris)
    • **type iii:** antigen-antibody complexes (e.g., SLE, Arthus reaction, serum sickness)
    • **type iv:** T-cell–mediated (delayed hypersensitivity) (e.g., allergic contact dermatitis, tuberculosis, transplant rejection)
37. **Kaposi Sarcoma most common cause now is AIDS.** KS is from **human herpes virus 8.**
38. Atopic dermatitis is a common skin disorder associated with **overactivity of mast cells and the immune system.** Look for a history of:

- **Asthma**
- **Allergic rhinitis**
- Family history of atopic disorders
- Onset before age 5, very **rare to start after age 30**

39. **IgE levels are elevated** in atopic dermatitis.
40. Psoriasis is characterized by **silvery, scaly plaques** that **are not itchy most of the time.** Less than 10% have arthritis. Extensive disease is associated with depression.
41. Pityriasis rosea is an idiopathic, transient dermatitis that **starts out with a single lesion** (herald patch) and then disseminates. It can look like secondary syphilis but it spares the palms and soles. It is transient, but if symptomatic it is treated with steroids or ultraviolet light.
42. Seborrheic dermatitis is a **hypersensitivity reaction to a dermal infection** with noninvasive dermatophyte organisms.
43. **Bullous Pemphigoid:**This is a much **milder disease than pemphigus**
44. **Erysipelas:Erysipelas** is a much **more severe disease** than impetigo because it occurs at a deeper level in the skin. Erysipelas is much more often **from Streptococcus** than Staphylococcus. Erysipelas invades dermal lymphatics and causes bacteremia,leukocytosis, fever, and chills.
45. Skin infections with group A beta hemolytic Streptococcus can cause **glomerulonephritis** but **not rheumatic fever.**
46. **Size of infection. Folliculitis < Furuncle < Carbuncle**
47. Tinea corporis = body
    Tinea manus = hand
    Tinea pedis = foot
    Tinea cruris = groin ("jock itch")
48. **Toxic epidermal necrolysis (TEN):** rash with mucous membrane involvement and adds Nikolsky sign.
49. **Red plaques with silvery white scales and sharp margins →psoriasis**
50. **A febrile patient with a history of diabetes presents with a red, swollen, painful lower extremity. →cellulitis**
51. **55 year old obese patient presents with dirty, velvety patches on the back of neck. →acanthosis nigricans. check fasting blood glucose to rule out diabetes**
52. **A lesion characteristically occurring in a linear pattern in areas where skin comes into contact with clothing and jewelry→ Contact Deramatitis**
53. **A painful, recurrent vesicular eruptions of mucocutaneous surfaces→ Herpes Simplex**
54. **Inflammation and epithelial thinning of anogenital area, predominantly in postmenopausal woman. →Lichen Scleosus**
55. **Atopic dermatitis is commonly associated with asthma and allergic rhinitis.**
56. **Contact dermatitis is type IV Hypersensitivity reaction that results from contact with an allergen to which the patient has previously been exposed and sensitized.**
57. **Atopic dermatitis .lichentification,excoriation and ill defined,scaling,erythema are characteristic.**
58. **A rash commonly involving the extensor surfaces? Think**

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Psoriasis. A rash commonly invoving the flexor surfaces? Think Atopic dermatitis.

59. **Psoriasis classically presents with the Auspitz sign (bleeding when scale is scraped).**
60. **Target lesions →Erythema Multiforme**
61. Varicella Zoster. The unilateral dermatomal distribution of grouped vesicles on an erythematous base is characteristic.
62. A Poxvirus infection →Molluscum Contagisum→most common in young children and in AIDS patients. The dome shaped, fleshy, umbilicated papule on child's eyelid is characteristic.
63. Warts are acused by HPV types. Some subtypes of HPV especially 16 and 18 can lead to squamous malignancies.
64. The classic genital wart is a cauliflower like papule or nodule appearing on the glan penis, the vulva or the perianal region.
65. Impetigo → dried pustules with a superficial golden brown crust are most commonly found around the nose and mouth. Causative organisms→group A streptococcal and staphylococcal organisms.
66. Tinea versicolor caused by Malassezia furfur, a yeast that is part of normal skin flora. →(spaghetti and meatballs pattern of hypea and spores) treatment →ketoconazole or selenium sulfide.
67. Tinea pedis: presents as chronic interdigital scaling with erosion between the toes "athlete's foot" or as a thickend , scaly skin the soles and interdigital web spaces. Asymmetric involvement of the hand is typical.
68. Scabies caused by sarcoptes scabiei. treatment 5%permethrin.
69. Decubitus ulcers are most commonly seen in bedridden patients who lie in the same spot for too long.
70. Acanthosis nigricans .velvety,dark brown epidermal thickening of the armpit is seen with prominent skin fold and feathered edges.
71. Lichen planus → koebner's phenomena
72. Bowen's disease is a form of SCC (squamous cell carcinoma) insitu.
73. Mycosis fungoides (cutaneous T- cell lymphoma) not a fungus but rather a slow, progressive neoplastic proliferation of T cells. More common in males than in females.
74. Screen for syphilis with a rapid plasma reagin (RPR) or Venereal Disease Research Laboratory (VDRL) test. Confirm a positive test with a fluorescent treponemal antibody absorbed (FTA-ABS) or microhemagglutination (MHA-TP) test because false-positive results occur with the RPR and VDRL

tests, classically in patients with lupus erythematosus. Once syphilis is treated, the RPR and VDRL tests become negative, whereas the FTA-ABS and MHA-TP tests often remain positive for life. You also can scrape the base of a genital chancre or condyloma lata and look for spirochetes on dark-feld microscopy.

75. **How is syphilis treated?**
With penicillin. Use doxycycline for penicillin-allergic patients

76. **How do you recognize erythema infectiosum (ffth disease) in children?**
What causes it? Look for the classic "slapped-cheek" rash confluent erythema over the cheeks looks like someone slapped the child across the face) accompanied by mild constitutional symptoms (e.g., low-grade fever, malaise). One day later, a maculopapular rash appears on the arms, legs, and
trunk. The disease is caused by parvovirus B19, the same virus that causes aplastic crisis in sickle cell disease.

77. Vitiligo is characterized **by skin depigmentation of unknown etiology. It is associated with autoimmune conditions such as pernicious anemia, hypothyroidism, Addison disease, and type 1 diabetes.** Patients often have antibodies to melanin, parietal cells, and thyroid peroxidase.

78. Atopic dermatitis is a chronic allergic type of condition that begins in the first year of life with red, itchy, weeping skin on the head, upper extremities and sometimes around the area a diaper covers.The clue to diagnosis is a family and/or personal history of allergies (e.g., hay fever) and asthma.

79. Seborrheic dermatitis causes the common conditions known as cradle cap and dandruff, as well as blepharitis (eyelid inflammation).

80. ***Tinea capitis*** (scalp): Mainly affects children (highly contagious), who have scaly patches of hair loss and may have an inflamed, boggy granuloma of the scalp (known as a kerion) that usually resolves on its own.
Tinea cruris (jock itch): More common in obese males; usually is found in the crural folds of the upper, inner thighs.

81. ***Tinea unguium*** (onychomycosis): thickened, distorted nails with debris under the nail edges.

82. ***Tinea corporis*** (body/trunk): Look for red ring-shaped lesions with raised borders that tend to clear centrally while expanding peripherally.

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83. Oral antifungals must be used to treat tinea capitis and onychomycosis; the other infections can be treated with topical antifungals (imidazoles such as miconazole, clotrimazole, or ketoconazole) or griseofulvin, which is better for severe or persistent infections.

84. Visualize the fungus via a microscope after scraping the lesion and performing a potassium hydroxide (KOH) preparation, or culture the specimen.

85. Scabies is caused by the mite *Sarcoptes scabei,* which tunnels into the skin and leaves visible burrows, classically in the finger web spaces and flexor surface of the wrists.

86. Psoriatic lesions are classically described as dry, well-circumscribed, silvery, scaling papules and plaques that are *not* pruritic. Classic lesions are found on the scalp and extensor surfaces of the elbows and knees.

87. **Dermatitis herpetiformis** is associated with celiac disease.

88. Dysplastic nevus syndrome is a genetic condition with multiple dysplastic-appearing nevi (usually more than 100 moles). Also look for a family history of melanoma. Treat with careful follow-up, excision or biopsy of any suspicious lesions, avoidance of sun exposure, and sunscreen use.

89. **Basal cell skin cancer almost never develops metastases.**
it may be locally invasive and destructive.

90. Stomatitis is an inflammation of the mucous membranes of the mouth. The classic finding is fissuring of the corners of the mouth (angular stomatitis). Watch for deficiencies of B-complex vitamins (riboflavin, niacin, pyridoxine) or vitamin C.

91. Paget disease of the nipple presents as a unilateral, red, oozing or crusting nipple in an adult woman that fails to respond to typical dermatology treatments.

92. Pemphigus vulgaris is a potentially life-threatening autoimmune disease of middle-aged and older patients. It presents with multiple bullae, starting in the oral mucosa and spreading to the skin of the rest of the body. Biopsy can be stained for antibody (an IgG antibody to desmoglein III, which is
associated with desmosomes) and shows a lace like or fishnet immunofluorescence pattern.
Treat with oral corticosteroids.
Bullous pemphigoid is a similar but milder condition that results in a linear immunofluorescence pattern (different antibody) and is treated similarly.

93. Rosacea often looks like acne but begins in middle age. There are numerous triggers for rosacea, including sun exposure, emotional stress, alcohol consumption, spicy foods, and hot weather.

Look for **rhinophyma** (bulbous red nose) and coexisting blepharitis. Treat with topical metronidazole or oral tetracycline.

94. Lice (pediculosis) can involve the head (caused by *Pediculus capitis;* common in school-aged children)

95. Tinea versicolor (also known as pityriasis versicolor) is a Pityrosporum fungal infection that presents most commonly with multiple patches of various size and color (brown, tan, and white) on the torso of young adults. It often becomes noticeable in the summer because the affected areas fail to tan and look white. Diagnose from lesion scrapings (KOH preparation). Treat with selenium sulfide shampoo or topical imidazoles.

96. Macule <1 cm; flat spot (nonpalpable, just visible) Freckles, tattoos
Patch >1 cm; otherwise, same as macule Port-wine birthmarks
Papule <1 cm; solid, elevated (palpable) Wart, acne, lichen planus
Plaque >1 cm; otherwise, same as papule and flat-topped Psoriasis
Nodule >1 cm; palpable, solid lesion; not flat-topped Small lipoma, erythema nodosum
Vesicle <5 mm; elevated, circumscribed lesion
containing clear fluid (small blister) Chickenpox, genital herpes
Bulla >5 mm; otherwise, same as vesicle (large blister) Contact dermatitis, pemphigus
Wheal Itchy, transiently edematous area Allergic reaction

97. Telogen effluvium: This is the loss of hair in response to an overwhelming physiologic stress,such as cancer and malnutrition.

98. Alopecia areata :This is an autoimmune disease in which antibodies attack the hair follicle and destroy hair production.

99. Acne is more common in girls but severe in boys.

100. Stasis dermatitis is a hyperpigmentation built up from hemosiderin in the tissue.

101. Atopic dermatitis is an extraordinary pruritis disorder characterized by high IgE levels.

102. Basal cell carcinoma >surgery>Mohs microsurgery.

103. Nikolsky sign present in staphylococcal scalded skin syndrome(SSSS). Nikolsky sign also present in toxic epidermal necrolysis.

104. Pediculosis is skin infestion by lice.

105. Paronychia is an infection loculated under the skin surrounding a nail.

106. Stevens-Johnson syndrome(SJS) is sometimes called erythema multiforme major.

107. **Systemic Lupus Erythematosus Skin:** Four of the manifestations of SLE are of the skin:

1. Malar rash
2. Discoid rash

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3. Photosensitivity
4. Oral ulcers

108. **Scleroderma (Systemic Sclerosis)/CREST: Skin manifestations:** fibrosis of the hands, face, neck, and extremities; telangiectasia and abnormalities of pigmentation occur.

109. Dermatomyositis presents with:
- Malar involvement
- **Shawl sign:** erythema of the face, neck, shoulders, upper chest, and back
- **Heliotrope rash:** edema and purplish discoloration of the eyelids
- **Gottron papules:** scaly patches over the back of the hands, particularly the PIP and MCP joints.

The best initial test is **CPK** and **aldolase**. The most accurate test is a **muscle biopsy**.

110. Psoriasis Can be associated with nail pitting and psoriatic arthritis.

111. Melasma (chloasma) :Hyperpigmentation associated with pregnancy ("mask of pregnancy") or OCP use.

112. Albinism :increase risk of skin cancer

113. Cellulitis Acute, painful, spreading infection of deeper dermis and subcutaneous tissues. Usually from *S pyogenes* or *S aureus*. Often starts with a break in skin from trauma or another infection.

114. Dermatitis herpetiformis :Pruritic papules, vesicles, and bullae (often found on elbows).Deposits of IgA at tips of dermal papillae. Associated with celiac disease. Treatment: dapsone, gluten-free diet.

115. Cutaneous leishmaniasis—transmission →Sandfly →skin ulcers → treatment →Amphotericin B,sodium stibogluconate.

116. Tinea corporis : Characterized by erythematous scaling rings ("ringworm") and central clearing. Can be acquired from contact with an infected cat or dog.

117. Important Signs:

Darrier's sign: Urticaria pigmentosa (Mastocytosis)
- Auspitz sign: Psoriasis
- Nikolsky sign: A canthoytic disorders

Eg: Pemphigus, SSSS, TEN.
- Carpet tack sign: DLE
- Button hole sign: Neurofibromatosis
- Apple jelly nodules: Lupus vulgaris
- Bulla spread sign: Pemphigus
- Gottron's sign: Dermatomyositis
- Oil drop sign: Psoriasis
- Shawl sign: Dermatomyositus
- Pseudo sign: Smooth muscle hamartomas
- Lesser Trelaut sign: E. Seborrheic keratosis

- Dennie morgan fold: Atopic dermatitis
- Hebra's triangle: Scabies
- Groove's sign: LGV
- CLUE Cells: Bacterial vaginosis
- Target Lesions: EMF
- Buschke-Ollendorf sign: Papular syphilis
- String of pearls: IgA dermatoses
- Pathergy test: Behcet disease, PG
- Kobeners phenomenon: LP, psoriasis, vitilgo, warts, Darriens, Xanthomas Reticulo histocytes
- Dimple Sign: Dermatofibroma

118. **TUBEROUS SCLEROSIS→**The characteristic triad is one of adenoma sebacum,epilepsy and mental retardation.

119. **Ash leaf spots** are hypopigmented dull white macules which are ovate or lance shape i.e., rounded at one end pointed at the opposite end. Ash leaf spots appear to be earliest cutaneous marker of tuberous sclerosis and are present in about 85% of patients with tuberou sclerosis.

120. Note: Dapsone also used for dermatitis herpetiformes

121. Vitiligo lesions are depigmented

122. Albinism lesions are hypopigmented

123. In AIDS patients, a very severe, crusting and non-itching form of scabies develops = NORWAGIEN SCABIES

124. Scabies involves palms and soles only in children

125. Oral Isotretinoin (vitamin A) is highly teratogenic, raises LFTS and also deranges lipid profile..... so regular LFT and Lipid profile must be monitored and also make sure adequate CONTRACEPTION before prescribing to female.

126. Comedo (black/white head)---->Nodules---->Rupture--->Pustule----->scar = ACNE VULGARIS...treat ... mild: topical benzoyl peroxide, vitamin A.... mod: add topical antibiotics (erhtyromycin/ doxy)..... severe: add oral isotretinoin or Mitoxantrone

127. Valvety hyperpigmentation with warty appearence leading to pronounced ridging of skin = ACANTHOSIS NIGRICANS.... ass with diabetes, insulin resisitance, obesity, PCOS, gastric carcinoma

128. If >30% TBSA involved with positive nikolsky sign = TOXIC EPIDERMAL NECROLYSIS

129. If erythema multiforme severe that it involves the mucous membranes with positive nikolsky sign (10% TBSA involved) = Steven jonson syndrome

130. Target like lesion <5cm on trunk without mucouc membrane involvement = Erythema Multiforme (ass with mycoplasma, herpes and sulfa drugs)

131. Red, hot, swollen lesion on leg which is blanchable = Cellulitis

132. Red, hot, sowllen lesion on face = Erysipearls

133. Impetigo + Ulcer = Ecthyma

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134. Vesicles, pustules with Honey colored crusted lesions.... IMPETIGO..... treat : mild... topical mupirocin, fusidic acid..... severe: oral penicillin..... if allergic to penicillin (Erythromycin)

135. HCV + patient with 6p (painful, pruritic, planar, purple, polygonal flat topppe papules on feet) with white wickman striae and fine lacy pinhead lesions in oral cavity with +ve kobner phenomena.....LICHEN PLANUS..... treat with steroids, retinoids, cyclosporin, phototherapy

136. Blistering skin disease in sun exposed areas (back of hand, face) ass with HCV estrogen or iron overload = PORPHYRIA CUTANEA TARDA..... 24 hour urine uroporphyrin increased

137. Old patient with thick, tense wall bulla which not easily rupture, spares the oral cavity and negative nikolsky sign... BULLOUS PEMPHIGOID.... subepidermal layer involved / antibodies to BP-220 (hemidesmosomes)..... treat with steroids, mycophenolate

138. <40 years with thin wall bulla that easily rupture..oral cavity, scal face, trunk with positive Nikolsky sign = PEMPHIGUS VULGARIS..... ass with penicillamine, ACEI..... autoantibodies too desmoglian (suprabasal / intra-epidermal desomosomes involved)..... treat with steroids, cyclophoshphamide

139. An HIV/Parkinson patient with erythematous, greasy, flaky rash on scalp/eyebrows/nasolabial folds/mid chest= SEBORRHIC DERMATITIS.... treat with topical antifungals (ketoconazole) and zinc pyrithione

140. Pruritic, oval lesions with scale of collatre/Herald patch with christmas tree appearence.....PYTRIASIS ROSEA.....resolves spontaneously but must differentiate from SECONDARY SYPHILIS (rash of secondary syphilis involves palms and soles)

141. Adult with non-pruritic, silvery scaly rash on EXTENSOR surface....PSORIASIS....+ve kobner phenomena/auzpitz sign.....treat with skin care, moisturizer topical steroids, topical tacrolimus, topical vitamin A,D, for extensive : use UV, PUVA, TNF-a blockers, Methotrexate

142. Adult with pruritis, scratchy, scaly rash on FLEXOR surfaces, = ATOPIC DERMATITIS..... h/o of asthma and allergy will be there..... treat with skin care, moisturizer, topical steroid, topical tacrolimus, antibiotics for infections, phototherapy if severe...

143. Urticaria →This is a form of allergic reaction that causes sudden swelling of the superficial layers of the skin. In addition to being caused by insects and medications, urticaria can also be caused by physical agents such as:• **Pressure** (dermatographism)• **Cold**• **Vibration.**

Unit 13

SECRETS OF COUNSELLING

ABNORMAL CERVICAL SMEAR

Hello Mrs. Smith, I am Dr. XYZ, senior house officer in the department of obstetrics and gynaecology. We have got the results of your smear test back. I am afraid we have detected some abnormal cells. Let me explain what it means.

Mild, CIN I: Some of the cells from the cervix have shown some changes. This could be due to infection. So we will check and treat if there is any infection. It is necessary to repeat the cervical smear and then we will decide the further course of action. I would like to reassure you that this is not cancer.

Moderate, CIN II: Some of the cells from the cervix have undergone changes. So we would like to do another test called colposcopy. Here we have a direct look at the cervix with a microscope. At the same time a biopsy can be taken. We will let you know about the biopsy as soon as the report is back. I would like to reassure you that this is not cancer. But it might develop into cancer if left alone untreated. The treatment of abnormal cells is quite a minor one and if the treatment is done early enough, it almost always leads to a complete cure. But you need to have a smear test every year to check that everything is still fine.

Severe dyskaryosis, CIN III: Some of the cells from the cervix have undergone changes. So we would like to do another test called colposcopy. Here we have a direct look at the cervix with a microscope. At the same time a biopsy can be taken. We will let you know about the biopsy as soon as the report is back. I would like to reassure you that this is not cancer. But it might develop into cancer if left alone untreated. The treatment of abnormal cells is quite a minor one. But you need to have a smear test every year to check that everything is still fine.

If not all the cells are removed, I am afraid we would do further tests to know the extent of the disease. You might have to have a hysterectomy then. I am sorry about the bad news. I am going to arrange for you to have a biopsy. Here are some leaflets to read. If you have further doubts don't hesitate to ask.

Thank you!

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ALZHEIMER'S DEMENTIA (Counselling of Relative)

ey Points

- Alzheimer's disease is usually progressive with mental function getting steadily worse. Some problems such as aggression may improve over time. The rate of change and the length of life vary greatly.
- Lock up any rooms in the house that are not in use, the patient will not notice this restriction.
- To lock up any drawers which contain important papers or easily spoiled items. This will
- prevent the patient storing inappropriate things in them.
- Remove locks for the lavatory so that the patient cannot get locked in.
- Normal sexual relationship will probably stop.
- The relative should psychologically prepare for the day when the patient no longer recognizes
- him. This can be a great blow.
- Day care for the patient is available. It will give much needed respite from the thankless task of looking after the patient (to the carer).
- Advice the relative to apply for an attendance allowance.
- Alzheimer's disease societies do exist (give phone number).

CROHN'S DISEASE

ood morning Mr. Smith, I am Dr. XYZ senior house officer in the department of medicine, I would like talk to you about your condition. In view of your symptoms, diarrhoea, weight loss, bleeding, dominal pain, etc., we have do some investigations. I am afraid we have diagnosed a condition lled Crohn's disease. It is also called inflammatory bowel disease.

am going to explain it to you. This means that the lining of the bowel is inflamed and that is why you e experiencing those symptoms. The cause for the inflammation is not known. Unfortunately there is o cure for this condition, but we can definitely offer you treatment to relieve your symptoms.

e are going to start you on some medication. One of them is prednisolone, which will keep the flammation under control. The other medicines are called sulphasalazine and azathioprine. We will so give you a course of antibiotics called metronidazole, to get rid of any gut infection.

addition to these drugs you need to be careful with your diet. The dietitian will talk to you as well.

rohn's control: We will monitor your progress regularly by clinic appointments and blood tests. In me chronic and resistant cases, we sometimes advice surgery. This will involve removing the seased part of the bowel.

CLEFT LIP & PALATE

Good morning Mrs. Smith I am Dr. XYZ, senior house officer in the department of paediatrics. Congratulations on the birth of your baby boy. I came to talk to you about the defect in his upper lip. This is called a cleft lip. The defect also extends to the roof of his mouth. And this is called a cleft palate. This is due to the failure of fusion of the two parts of lip and the palate in the middle. I understand that you are anxious to know what will happen to him. I would like to reassure you that this is not a life threatening condition.

In the near future, he will need surgery to repair the defect. I will show you some photos of babies that have undergone surgery. The operation is performed by plastic surgeons. It is possible to close the defect and leave behind only a very small scar. The lip is repaired at 3 months and the palate at 1 year.

However at this moment it is important to concentrate on his feeding. If you are breast feeding you might need some help from our breast-feeding nurse. If you are planning to bottle feed, he will need a special teat so that the defect of his palate will be covered. This prevents milk from going into his nose

Other than that you need not take any other special precautions. I will also refer you to the CLAPA team cleft lip and palate association. One of the nurses from this team will talk to you again about feeding techniques.

Counselling - Down's Syndrome:

Hello Mrs. Smith I am Dr. XYZ, senior house officer in the department of Paediatrics. Congratulations on the birth of your beautiful boy. I would like to have a little chat to you about him. You might have noted that he looks slightly different to other babies. I have examined him thoroughly and I am sorry to have to tell you that I suspect he has a condition called Down's syndrome. Have you heard about this at all?

Well Down's syndrome is a chromosomal disorder. Now, children with Down's syndrome can have a variety of features. The most obvious ones are the upward slanting eyes. They have a large tongue and can be rather floppy. This might lead to feeding problems in the early life. Occasionally these children can have heart defects and malformations in their guts. This does not seem to be the case with your son, as I have listened to his heart and examined his tummy. However we will arrange a heart scan to make doubly sure. I don't want to paint a very gloomy picture. Children with Down's syndrome are very pleasant and lovable. They enjoy music very much. At the moment my diagnosis is relying entirely on the clinical features. That why it is important to do a blood test to look at the chromosomes to confirm this.

It must be a lot for you to take in, in one session. I will give some written information to read through and if you have

any questions later on we will be happy to help.

Thank you, Mrs. Smith.

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Epilepsy – Counselling:

Good morning Mrs. Smith I am Dr. XYZ, senior house officer in the department of Obstetrics and Gynaecology. You were brought to A and E fitting. It was necessary for us to start you on a medication to control these fits, as they have become more frequent. So we started you on a drug called Carbamazepine. Since then you are doing extremely well. We have also done a few tests like tracing of your brain and a scan. We have come to a diagnosis that you have Epilepsy. Epilepsy means that there is some abnormal electrical activity in your brain. This can be controlled with the help of drugs. Refer: Epilepsy.

Unfortunately we don't know the cause.

Mrs. Smith, since you are being discharge today, I have some advice for you.

You have to take your medication regularly. If you suddenly stop them this could precipitate a severe fit. There are also some side-effects. The most common ones are blurring of vision, dizziness and unsteadiness. If you get fever, sore throat, rash, mouth ulcers, bruising or bleeding please contact your GP. You have to inform the DVLA. You will not be able to drive till you are fit free for a period of one year or you have fits only during sleep for three years. You shouldn't operate heavy machinery. Teachers and pilots need to change their profession). Antiepileptics may reduce the affect of pills.

If you wish to get pregnant, you should discuss this with your doctor first. It is important to take dequate folic acid supplements before and during pregnancy to prevent neural tube defects. rophylactic Vitamin K is recommended before delivery as there is increased risk of neonatal bleeding. reast-feeding is acceptable.

- ✓ Please do not lock bathroom doors.
- ✓ Avoid swimming and cycling alone.
- ✓ Wear an epilepsy card or bracelet.

our GP has been informed of your condition. If you have any questions please feel free to ask

Counselling -- Febrile convulsions:

ntroduction:

know Mrs. Smith that was a very frightening experience for you. You may even have thought that our child was dead or dying. Many parents think that when they first see a febrile convulsion. owever febrile convulsions are not as serious as they look.

is an attack brought on by fever in a child usually aged between 6 months and 4 or 5 years. A onvulsion is an attack in which the person becomes unconscious and usually stiff, with jerking of the rms and legs. It is caused by a storm of electrical activity of the brain. The words convulsions, fit and eizure mean the same thing.

revention of Febrile convulsions: If your child is having fever, you can take the temperature by lacing the bulb of the thermometer under his armpit for 3 minutes with his arm held against his side. eep him cool. Don't over clothe him or over heat the room. Give plenty of fluids to drink. Give hildren's paracetamol medicine to get his temperature down. If he seems ill or has earache or sore hroat, let your doctor see him in case he needs any other treatment such as antibiotics.

When your child is fitting you should lay him flat on his side, with his head at the same level or slightly ower than his body. Note the time and wait for the fit to stop. It is not necessary to do anything else.

We will give a medicine to insert into your child's bottom. This is called rectal diazepam. If the fit carries for more than 5 minutes give rectal diazepam. This should stop the fit in 10 minutes. If it doesn't bring him up to the hospital or dial 999 if necessary. In any event let your doctor what has happened.

The child doesn't suffer discomfort or pain during a convulsion. The child is unconscious and unaware of what is happening. The convulsion is much more disturbing to you than the child. Mrs. Smith if you have any doubts please don't hesitate to ask.

Other points:

Incidence: 1 in 30 will have one by the age of 5 years. The risk of having another gets rapidly less after the age of 3 years.

It is not epilepsy. 99 out of 100 children with febrile convulsion never have convulsion after they reach school age, and never have fits without fever.

Febrile convulsions lasting less than 30 minutes will never cause permanent brain damage.

Counselling -- Inguinal Hernia:

Good morning Mr. Smith I am Dr. XYZ senior house officer in the department of Surgery. I would like to have a chat with you regarding the lump in your groin. You came here with abdominal pain and constipation and after examining you I came to the diagnosis that you are having an inguinal hernia in the right groin. (Other predisposing conditions: chronic cough, urinary obstruction, heavy lifting, ascites and previous abdominal surgery).

The hernia is a defect in the tummy wall through which the contents of the tummy will try to come out when you cough or strain at stool. If we don't treat, it grows and gets twisted thereby reducing the blood supply and causing the death of the tissue. To prevent this the hernia has to be closed surgically. Our consultant Mr. John who is very experienced in this will perform the operation. For the operation you will be put to sleep. Our anesthetist will have a word with you before the operation. It is advisable to stop smoking before the operation. You have to come to the hospital a day before the operation, so that we can prepare your gut for surgery. We may have to transfuse bloods during the operation.

The hernia will be reduced, by incising the skin above the hernia and then the contents are placed back in the abdomen. A nylon mesh is kept in place to strengthen the tummy wall and the skin is closed with sutures. The mesh remains there permanently and will not cause any problem. After the operation you will wake up in the recovery room and you will be attached to an IV cannula and a catheter. You can go home in a day or two, depending on how you recover.

Mr. Smith as with any operation there are few complications associated with this operation. 1) Pain: it will be sore for a few days and we will give painkillers. 2) Infection may develop in the wound which can controlled with antibiotics. 3) Bleeding or haematoma. In spite of all the care we take there is a slight chance of recurrence of the hernia.

Mr. Smith you can return to work in 4 weeks and full activity in 8 weeks. A follow up will be arranged at 6 weeks.

If you have any doubts please don't hesitate to ask. Thank you.

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Counselling - Birth asphyxia:

(hypoxic ischaemic encephalopathy- HIE)

Hello Mrs. Smith I am Dr. XYZ, senior house officer in the department of paediatrics. I would like to have a little chat with you regarding your son Richard. As you know we have to admit him to the special care baby unit yesterday. Unfortunately he went through a tough time when he was born. He was very distressed because of the cord prolapsed and his brain was starved of oxygen for a while. Due to this he was floppy when he came out and needed help with his breathing. As you can see now he is on a ventilator, a machine that breathes for him.

Unfortunately he also started to fit yesterday and he is on medication to control his fits. We have done a scan of his brain, which shows some swelling. We are hoping that this will go down in the next few days.

Is very early and very hard to say what the long term effects of this will be. He might recover with only a minor physical disability or he might be more disabled. It is really hard to say at this point.

We need to monitor his progress carefully over the next few weeks. We will also be doing more blood tests and head scans. We will let you know any results immediately.

In the mean time try not to worry too much, as these are early days. I know it is hard. We will encourage you to spend as much time with him as possible, here on the baby unit. Before discharging your baby we will inform the physiotherapist, health visitor, social worker and GP. We will arrange regular appointments for frequent follow up of Richard.

I will give you the telephone number for Cerebral palsy helpline where you can meet parents of children with similar condition.

If there are any questions please ask us. Thank you! Mrs. Smith.

Counselling – HIV:

Good morning Mr. Smith I am Dr. XYZ, senior house officer in the department of Medicine. The result of your blood test came today morning. Are you anxious to know the result?

I am afraid to say that the blood test confirmed that you are having the HIV virus which cause AIDS. I can understand that this is very shocking news for you. I would like to ask you a few questions to put things in perspective.

H/o blood transfusion? Do you use any recreational drugs?

Do you practice safe sex? What are your sexual preferences?

Mr. Smith having the virus doesn't mean that you are having AIDS. We really don't know how the disease progresses. Some people can be free of symptoms for a long time. However it is important that you use medication to prevent further deterioration in your condition. The symptoms you might experience could be body aches, lethargy, swelling of your glands, headache, weight loss, skin infection, diarrhea, etc. You will also require regular follow up with us.

Mr. Smith you should practice safe sex. You shouldn't donate blood or share needles and razors. This is an entirely confidential matter but I feel you should tell your GP and your partner.

(vaccinations contraindicated in HIV: BCG, oral polio and yellow fever)

Counselling – Leukaemia:

Introduction: Hello Mr. Smith. I would like to talk to you about your son's condition. He has been suffering from multiple bruises, body aches and recurrent infections. We have done a few blood tests, which suggest that he have a condition called acute leukaemia. This means that his bone marrow is producing a lot of abnormal white cells. This is why he has been getting frequent infections.

I am sorry to say that this is a form of cancer. However we would first have to confirm the diagnosis by doing a bone marrow test. After that we will start him on chemotherapy to suppress the cancer. There are some side effects from the drugs like hair loss, vomiting, bleeding and diarrhoea. We hope his condition responds to chemotherapy. If not he might need a bone marrow transplant.

I know that this is a lot of information to digest at the moment. We will explain things on a daily basis If you have any doubts don't hesitate to ask. Thank you.

Refer: AML, CLL, CML and Leukaemia.

Counselling Mesothelioma:

Hello Mr. Smith I am Dr. XYZ senior house officer in the department of medicine.

I am afraid I have some bad news for you. The biopsy showed that you have a mesothelioma, which is tumour of the pleura, the lining of the lung. This is the cause of your symptoms. Unfortunately th condition is very hard to treat and the only thing we can do is to try and relieve your symptoms.

You have been admitted with the complaints of breathlessness, chest pain and weight loss. As yc know we have done some investigations. In one of them, we removed a bit of tissue from the lining your lung (biopsy).

This condition is usually seen as a result of chronic exposure to Asbestos. Due to the mesotheliom there is fluid accumulation in between the layers of the pleura. We can tap this fluid on a regular bas to relieve your breathlessness. There is no cure otherwise.

I am very sorry about the bad news.

(Mean survival: 2-3 years, it occurs 20-40 years after the exposure to asbestos. Get consultant counsel further).

Nappy rash – Counselling:

Hello Mrs. Smith, I am Dr. XYZ, senior house officer in the department of paediatrics. You brought yc son Robert as he has a sore bottom. I had a look at him. It appears to me that he has a comm condition called ammonical dermatitis.

It is quite commonly seen in small children. It is due to irritation of the skin from the urine in the nap However it is a fairly easy condition to treat. You will have to change his nappy frequently. You apply an emollient cream or a nappy cream to prevent irritation to other areas. Also avoid any ti fitting clothes. If possible give your baby some time off from the nappies if you can. If you are us reusable nappies, you have to wash them thoroughly after use.

This condition should soon go away. However if it is no better in a few days time, please come back the ward to see

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me again.
DD, Nappy rash:
Ammonical dermatitis -- spare skin creases,
Seborrheic dermatitis -- involves creases and scalp and face.
Candida -- satellite lesions.
Psoriasis -- skin lesions elsewhere on the body.
Treatment for candida: surface swabs, start topical nystatin for 5 days. Check for oral thrush, if present - oral nystatin and topical nystatin.

Counselling -- Needle stick injury:

Hello Mrs. Smith I am Dr. XYZ, senior house officer in this A & E department.
I can see you have brought your little boy Thomas. I understand he pricked himself with a needle. I need to ask you a few questions.
Do you know whom the needle belongs to? Where has he found it?
How long ago did the injury happen? Have you cleaned the wound?
When did he last have his tetanus immunization?
(if mother knows the owner, ask whether that person is Hep.B+ve. If Hep.B+ve, the child needs HIBG along with vaccine).
There are a few things we need to do. We will dispose of the needle for you. Thomas needs a blood test to check his hepatitis status. We will then give him the first dose of the vaccine. He will need two further boosters at 1st month and 2nd month, which he should get from your GP. He will also need another blood test after the vaccination. Regarding the risk of AIDS, I can reassure you that the risk is very small.
I hope I have cleared all your doubts. I will write to your GP about what needs to be done. It is important that Thomas receives the full course of the immunization.
I will give you an information leaflet as well. If you have any doubts later please don't hesitate to contact us.
Thank you Mrs. Smith.

Counselling: Pre-eclampsia:

(BP: systolic >30 and diastolic >20 over booking BP or BP >160/100 or BP 140/90 with proteinuria).
Good morning Mrs. Smith I am Dr. XYZ senior house officer in the department obstetrics and gynecology. You are now 30 weeks pregnant and we have been monitoring your BP closely over the last 2 weeks. I am sorry to say that your BP is still high. This condition is called Pre-eclampsia or pregnancy induced hypertension. This condition needs to be managed very carefully to prevent any complications to you or your baby. I am afraid that we will have to admit you to the hospital to control your BP. You need to take bed rest. We'll also start you on medication to lower your BP. It is important to test your

urine and blood regularly. We'll also check the well being of the baby by CTG and scan. We hope that your BP will be controlled by these measures.
If how ever there is a problem we might need to deliver the baby early.
Pre-eclampsia: PIH with proteinuria + oedema. The arterial wall doesn't distend enough to allow sufficient blood flow to
the placenta in late pregnancy, and increasing BP is a mechanism, which partially compensates for this.
Symptoms: headache, fever, chest pain, epigastric pain, vomiting and visual disturbance. There may be tachycardia, shaking, hyperreflexia, irritability and papilloedema.
Effects: plasma volume is reduced, increased peripheral resistance. If BP is >180/140 microaneurysms develop in the arteries. DIC may develop. Uric acid level is increased.
Management: admit, measure BP 2-4 hourly. Weigh daily, test urine for protein, monitor fluid balance, check uric acid, renal, liver and platelet function. Do regular CTG and USG to check growth and biophysical profiles.
Methyldopa to reduce BP. If signs worsen delivery is the only cure (give H2-blockers if they go into labour).
Symptomatic pre-eclampsia and eclampsia: diazepam + hydralazine. Labetalol provides an alternative
Visual symptoms, twitching or ankle clonus indicate that the baby must be delivered urgently (by caesarean section).
Ergometrine should not be used for the third stage. Syntocinon may be used. Ergometrine further increases BP so would risk stroke.

Counselling Sterilization:

MALE: Hello Mr. Smith I am Dr. XYZ, senior house officer in the department of Surgery. I understand that you wish to have a sterilization operation.
I would like to ask you a few questions: have you completed your family? How many children have you got? What is the age of the last child? Have you considered other methods of contraception? Have you discussed this with your partner?
Sterilization is essentially irreversible. It involves a small operation on the tubes that carry sperm from the testicles to where they are mixed with the semen. These tubes will be cut or blocked. This doesn't effect your sexual function. You will still produce semen, but with no sperm in it.
The operation can be done under a local anaesthetic. A small cut is made on both sides of the scrotum. The tubes are then tied and cut. You can go home the same day. There shouldn't be any complications. You might be having some bruising or pain, which will resolve in a few days time.
You'll need to use some form of contraception for 2-3 months after the operation, because you will still be producing sperms. We will do a semen analysis and let you know when you are sterile. It is important that you understand that this procedure is permanent and irreversible.
FEMALE: Hello Mrs. Smith I am Dr. XYZ, senior house officer in the department of Obstetrics and Gynaecology.
I understand that you wish to undergo a sterilization operation. Have you completed your family? Are you in a stable relationship? How many children have you got? How old is your last child? Have you considered other modes of contraception? Have you discussed this decision with your partner?

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I must tell you that this is a premanent and irreversible procedure. It involves a small operation on your tubes. The tubes will be blocked so that the egg cannot travel down the tube. However you will still continue to have your periods. There are several ways of performing the operation. We will make a small incision on your abdomen and clip the tubes (mini- laparoscopy). You will need a general anaesthetic for the procedure. You can go home the next day.

I must tell you that there is a very small failure rate, i.e. 1-3 in 1000 chance of pregnancy.

Overall you will continue to have periods and your sexual activity should not be effected.

Counselling -- Termination of pregnancy:

ntroduction:

Questions to be asked before TOP:

How are you? Are you sure that you are pregnant?

Why do you want a termination? I don't mean to be intrusive but why have you considered this?

You have to live with the decision for the rest of your life. Have you discussed with your partner?

Have you considered the other alternatives like adoption of the baby?

f she chooses TOP: I will have to examine you and do a screen to confirm that you are pregnant. Investigations: chlamydia, cervical smear, bloods for Rh and grouping. If Rh -ve give Anti D to prevent problems in the future).

When was your last cervical smear?

s your menstrual cycle's regular? LMP?

Are you on any contraception?

s this a planned or unplanned pregnancy?

Any previous TOP?

Are you having any medical problems? Are you on any medication?

H/o smoking and alcohol.

Mrs. Smith as you are >9 weeks pregnant the TOP is done under general anesthesia. The (neck of the womb) cervix is

dilated and the womb is evacuated. When you wake up it may be sore and bleed. If there are no problems you can go

home the same day.

The **complications** associated with TOP are heavy bleeding, rarely perforation of the womb, infection (affects the tubes and may lead to infertility) and rarely incomplete removal.

Contraception: You can start the pill tomorrow if you wish.

For 2nd trimester abortions, labour is induced using intravaginal prostaglandin gel or pessaries eg. Gemeprost. Oxytocin to stimulate contractions and surgical removal of retained placenta.

After 14 weeks mortality and morbidity raises steeply with gestation.

4-stage medical TOP: (gestation <9wks) Counselling and USG, supervised mifepristone 600mg PO (disimplants the conceptus (CI: smokers >35yrs old; avoid aspirin and NSAID's for 12 days). A gemeprost 1mg pessary 36-48h later completes abortion. Follow up and scan at 12 days.

Counselling: TURP:

Hello Mr. Smith I am Dr. XYZ, senior house officer in the department of Surgery. I understand that you have a problem when passing urine. Your stream is not very good. You have also said that you need to go very often to the toilet. We have examined you and found that your prostate is enlarged. As it is a benign enlargement, we would like you to undergo an operation called TURP, transurethral resection of the prostate.

This means that we will insert a small cystoscope through your urethra. The end of the cystoscope has a heated cutting loop with which we can remove all the abnormal tissue. The procedure will be done under general anesthesia. The anesthetist will come and have a word with you.

There are a few risks associated with this operation. There is a small chance that you may become infertile after the operation. You might notice some blood in your urine for the first 2 weeks.

After the operation, you should not drive for 2 weeks. You need to avoid sex for 2 weeks. You ejaculate may be decreased and this is due to backward flow into the bladder. This can make the urine look cloudy. You might have to go to the toilet more frequently, but this should settle in a few weeks time.

Do you have any questions? Thank you Mr. Smith.

For **carcinoma of the prostate:** do PSA and serum alk phos to confirm metastatic Ca. Treatment options: Radiotherapy and analgesics for pain and Hormonal therapy with stilbesterol. If there is no metastasis prostatectomy and stilbesterol (orchidectomy can be an option).

Child with Diabetes - history taking and counseling:

Introduction:

How old is he?

Is he lethargic and drowsy?

Is he having temperature and any coughs and colds?

How much does he drink? How often does he go for a wee?

Does he wake up at night for a drink?

How is his appetite? Weight loss?

H/o diarrhoea?

Does is sting during wee?

H/o recurrent UTI?

Past h/o similar illness? H/o head injury, meningitis?

H/o immunization?

Family history of DM.

Points in Counselling:

Due to the lack of insulin, which is produced by the pancreas, the blood sugar always remains high. The child may pass a lot of urine and he may be dehydrated. There is an increased risk of infection and boils. It can't be cured but can be kept under control by insulin injections. The cause of this is not known. The good news is he can grow as a normal child with insulin. It is important that he takes insulin regularly. He should not skip meals. It is advisable to always carry sugary drinks or chocolate. He will go into hypoglycaemia if he skips a meal. Hypoglycaemia presents as irritability, sweating, drowsiness

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light-headedness and abdominal pain. It is important to recognise these symptoms. If he is ill he should still take insulin regularly with sugary drinks. Diet: advice from a dietitian, high-refined food and plenty of starches. Our diabetic nurse will have a word with you. Regular monitoring of blood glucose levels. Hyperglycaemia will cause damage to the body organs in the long run. So it is important to keep the blood sugar within the normal range.

He will have regular follow-ups. His GP will be informed. Here are some leaflets to know more about his condition. If you have any doubts please don't hesitate to ask. Thank you.

Hormone Replacement Therapy:

Introduction: (Good morning Miss Tracy, I am Dr. XYZ Senior house officer in the department of Obstetrics and Gynaecology. I would like to have a little chat with you regarding HRT, Hormone replacement therapy.)

Age? When was the last period? Menstrual irregularities?

We you on any contraception?

Any (vasomotor disturbances like) hot flushes, sweating and palpitations? Fractures? (prone to osteoporosis)

Any (vaginal dryness) vaginal and urinary infections, dyspareunia, bleeding, stress incontinence and prolapse? (also atrophy of breast, genitalia and skin.)

Psychosocial problems like irritability & depression.

Smoking, Hysterectomy and oophorectomy?

H/o DM, Heart disease, thyroid and psychiatric problems?

There are a few **contraindications** to HRT.

Were you diagnosed as having breast carcinoma or undiagnosed PV bleeding? (also breast feeding) and h/o clots in the legs (DVT or PE)?

There are a few SE like weight gain, cholestasis and vomiting.

Hot flushes and vaginal dryness respond to HRT. HRT postpones menopausal bone loss and protects against cardiovascular disease and ovarian carcinoma.

Women with uterus should receive oestrogen and progesterone preparations. This pill is similar to OCP but in very very low dose. If you notice any bleeding consult your GP. (endometrial biopsy).

Types of HRT: Oral, creams, pessaries, rings, transdermal patches and oestradiol implants.

When is HRT particularly desirable: - Premenopausal bilateral ooporectomy, hysterectomy, increased risk of

osteoporosis eg: inactive or smokers, ischaemic heart disease or risk factors like DM and hyper-cholesterolaemia and Rheumatoid arthritis.

Rule out thyroid and psychiatric problems before starting HRT as they present similarly.

Counselling helps psychosocial problems, contraception should be continued for a year after the last period (PoP, IUCD and barrier methods are suitable.)

Refer: HRT.

History taking and Counselling: IUCD:

Introduction:

Questions to be asked before inserting IUCD:

How old are you?

Have you completed your family? How many children have you got?

Are the deliveries normal?

Menstrual history? LMP?

H/o ectopics? H/o fibroids?

When was your last cervical smear?

Have you been treated for any genital infection?

H/o heart disease, DM and Wilson's disease?

Are you on any medication?

IUCD is a small plastic and copper device with two soft threads on the ends. It is in the shape of the letter 'T'. It stops the sperm from reaching the egg. It prevents the egg from settling in the womb. The IUCD doesn't interfere with sex. It needs to be changed once in 3-5 years.

Disadvantages of IUCD: the periods may be heavier or longer or painful. There is a small chance of infection. In the first 20 days your womb may expel the IUCD out. There is a rare chance of perforation. If you do become pregnant (1%) there is the risk of an ectopic pregnancy. The IUCD doesn't protect against STD.

Follow up: immediately after the next period and then once every 6 months. Regularly feel for the tail.

Come immediately to the hospital if the tail is lost, excessive bleeding, pain and fever.

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Unit 14

SECRETS OF BEHAVIOURAL SCIENCES & PSYCHIATRY

Question No. 1

A 23 yr old man presented to psychiatry department with sudden onset of behavioural disorder. He complained of listening voice which ordered him to abuse and attack his parents.

a. What is the diagnosis?
b. Write 3 differential diagnosis?
c. What is the drug of choice?

Answer:

a. Schizophrenia
b. Drug abuse like:
   i.Cocaine
   ii.Heroine
   iii.Cannabis
   iv.Charas
c. Risperidone and other antipsychotics

Question No. 2

A 50 yr old man just discharged from a Psychiatry ward is brought to the Emergency is 105F. He is confused and irritable. He has generalized muscle rigidity and dysarthria. His BP is 160/100 mmHg and creatinine kinase level is four times the normal.

a. What is likely diagnosis?
b. How would you treat this patient?

Answer:

a. Neuroleptic malignant syndrome
Lab: raised CPK, leucocytosis
b. 1. Stop antipsychotic drugs
2. Ensure hydration
3. Rx of hypothermia
4. Bromocriptine or dantrolene sodium
Procyclidine

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Question No. 3

A 18 yr old boy presented with progressive generalized muscle rigidity, catatonic posturing and high grade fever that he developed two days ago. Accompanying documents reveal that he has been on fluphenazine and haloperidol for the past two months on account of paranoid schizophrenia.

a. What is your provisional diagnosis?
b. What other symptoms/signs would you look for to confirm the diagnosis?
c. What factors in the history would help you to predict the likelihood of manifestation of this state?
d. What clinical findings and labortary investigations would confirm the diagnosis?

Answer:

a. Neuroleptic malignant syndrome. It is relatively rare, potentially fata idiosyncratic reaction to the treatment with antipsychotic drugs.
b. Clinical features: hyperthermia, muscular rigidity, autonomic instability. Associate features include involuntary movements catatonic posturing and altered/fluctuating level of consciousness
c. Risk/vulnerability factors-include younger patients, concurrent lithium administration and exposure to a wide range of dopamine-receptor blocking or dopamine depleting agents.
d. Diagnostic: depends on clinical grounds. CSF and CT scan are normal, EEG shows non-specific slow waves; total leukocyte count and creatinine phosphokinase are elevated.

Question No. 4

A 28 yrs old taxi driver has developed recurrent thoughts of having accidentally run over a pedestrian. Although he tries to convince himself that his worries are silly, his anxiety continues to mount until he drives back to the scene of the accident and proves to himself that no body lies hurt in the street.

a. What is the diagnosis?
b. Write differential diagnosis?
c. Give his management.

Answer:

a. Obsessive compulsive disorder
b. i. Panic disorder
ii. Depression
iii. Schizophrenia
iv. Bipolar disorder
v. Anxiety
c. Management:
1. Psychological treatment:
i. Response prevention
ii.Modeling
iii.Thought stopping (reduce obsession)
iv.Cognitive behavior therapy (CBT)
2. Pharmacological treatment: Antidepressant (SSRI, Clomipramine)

3. Psychosurgery:
Only in cases of chronic and severe OCD
i. sub-caudate tractotomy
ii. cingulotomy

Question No. 5

A senior civil servant was persuaded to seek medical advice because of his increasing bizarre behavior. He had slowed up mentally becoming indecisive. He complained of lack of energy. His appearance had changed his skin appearing sallow and hair coarse lacking lusture. O/E his pulse rate was 56/minute, regular, BP 130/80 mmHg, there was no goiter, his ankle jerk showed slow relaxation.

a. What is the diagnosis?
b. Give differential diagnosis.
c. How would you treat this illness?

Answer:

a. Depression
b. Differential Diagnosis:
1. Psychiatric disorders:
i. Alcohol misuse
ii. Amphetamine misuse and withdrawal
iii. Borderline personality disorder
iv. Dementia
v. Delirium
vi. Schizophrenia
2. Organic (secondary) affective illness:
i. Cushing syndrome
ii. Hyperthyroidism
iii. Corticosteroid treatment
iv. Brain tumor

c. 1. Pharmacological:
i. Tricyclic antidepressants (TCAs)
ii. SSRIs
iii. MAOIs
iv. Moclobemide
2. Psychological:
i. CBT
ii. Interpersonal psychotherapy
iii. Problem solving therapy
iv. Couple therapy
v. Family history
3.Social:
i. Assistance with social problems

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ii. Provision of group support
iii. Social Clubs
iv. Occupational therapy
v. Referral to social workers
vi. Self help groups
vii. Educational programme
viii. Informed & supportive family members

4. Electroconvulsive therapy
5. Transcranial magnetic stimulation (TMS)

Question No. 6

A 30 yr old male presents in psychiatric OPD. He says that he being chased by assailants who are trying to kill him because he is the President of America. His brother reports that he is confined to his house and talks of hearing voices that tell him that he will soon be murdered.

a. What is your diagnosis?
b. Write differential diagnosis?
c. Write management?

Answer:

a. Schizophrenia
b. Differential Diagnosis:

Other functional psychosis:

- ✓ Delusional disorders: absence of specific features schizophrenia
- ✓ Psychotic depression: prominent depressive symptoms
- ✓ Mood (affective) disorders: prominent manic symptoms
- ✓ Personality disorder: mood & schizophrenia symptoms (schizotypal)
- ✓ Puerpral pyschosis: acute onset after child birth

Organic disorders:

- ✓ Drug induced psychosis: evidence of drug or alcohol misuse, amphetamine
- ✓ Side effect of drugs: levodopa, methyldopa, corticosteroids
- ✓ Organic mental disorder: other evidence of seizures (partial complex epilepsy)
- ✓ Delirium: visual hallucination, impaired consciousness
- ✓ Dementia: age, established cognitive impairment
- ✓ Huntington disease: family history, choreiform movement

c. Management:

1. Admission to hospital
2. Antipsychotic drugs:

i. Typical (1st generation): Chlorpromazine, Haloperidol, Fluphenazine, Trifluperazine
ii. Atypical (2nd generation): Clozapine, Resperidone, Olanzapine, Quetiapine

3. Psychological treatment:

i. Reassurance
ii. General support
iii. CBT to cope with resistant patient

iv. Personal/family education to prevent relapse
v. Good doctor-patient relationship

4. Social treatment:

i. Social rehabilitation
ii. Shelter
iii. Employment
iv. Manage their accommodation and acceptance
v. Care programmed approach

5. Prevention of relapses:

i. Prophylactic treatment with antipsychotic
ii. Personal and family education

6. Counselling:

i. Regarding nature and treatment of disease
ii. Educate the patient that he/she must avoid from too much expression of emotion to prevent relapse

7. Follow up: weekly monitoring of WBC level because clozapine can cause agranulocytosis

Question No. 7

A 23 yr old lady had first episode of tonic-clonic fit with tongue bite and urinary incontinence. Her father is very anxious and worried. Cousel the father about illness of his daughter in relation to:

a. What is her diagnosis?
b. Further Investigations?
c. General measures?
d. Pros and cons of starting drug therapy?

Answer:

a. Epilepsy
b. EEG, CT/MRI brain with contrast
c. Avoid situation that could be dangerous or life threatening if further seizures occur (e.g driving, swimming, climbing on hills etc.)
d. Examiner's satisfaction

Epilepsy cannot be cured with medication. However, various medicines can prevent seizures. They work by stabilizing the electrical activity of the brain. You need to take medication every day to prevent seizures. Seizures are well controlled by medication in about 4 out of 5 cases.

Question No. 8

An 17 yrs old boy is admitted to hospital with two years H/O social isolation, odd behavior and academic decline. Psychiatric examination establishes anxiety and depression of mood, compulsive acts, recurrent intrusive and distressing thoughts and perfectionistic/ obsessional personality traits.

a. Enlist your differential diagnosis (atleast 4)

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b. What is the most likely diagnosis in this case?
c. Name 4 pharamcological agents likely to help this patient.

Answer:

a. Obsessive compulsive disorder, OCD with depression, major depressive episode, Schizophrenia, adolescent crisis of identity
b. Obsessive compulsive disorder
c. Clomipraine, fluoxetine, fluvoxamine, citalopram and venlafaxine

Breaking the bad news:

"Any news that adversely and seriously affects an individual's views of his or her own feature is considered as bad news."

There are many clinical situations where bad news has to be communicated to the patient and his or her relatives' e.g. disclosing the diagnoses and relapse of cancer, birth of a malformed baby or still birth or death of loved one. Breaking bad news is an unpleasant task and can be learned from senior physician or through own professional experience. Most patients or relatives expect full disclosure delivered with empathy, kindness and clarity. There are five different schools of thoughts and *bio-psychosocial model* has least limitations so strongly used in health setting.

A. Bio-psycho-social model:

This model provides clear, crisp, evidence based information on the patient conditions but tailors the flow and amount of information according to the needs of the patient. A vertical flow of all data on the disease (particularly the parts that the patient or his family not asked for), is avoided. The bad news is broken using the principles of effective communication, counseling and informational care listed above. The patient is encouraged to involve his family members, particularly the ones who can provide psychosocial support during the session.

This model suggests following steps for a session that aims at breaking the bad news:

Step-1: Seating and Setting: (Environment)

Exclusivity:

The environment where bad news is being broken can have serious repercussions on the outcome of the interview. Patient's mistrust and antagonism may simply result from a poorly chosen location. Therefore it is worth trying to find a private room where doctor and patient can focus on the subject attentively.

Involvement of significant others:

Some patients like to have family members or friends around them when they receive bad news. If there are more than few people supporting the patient, ask one person to act as representative. This gives patient support and alleviates some stress from the doctor in the face of an emotionally charged interview.

Seating arrangements:

It is advisable that interview takes place with both the doctor and the patient comfortably and respectfully seated next to each other, preferably at a distance of an arm's length. The arrangement should never impart an intimidating image of the doctor. Instead it should provide an appropriate setting for discussions and any emotional outbursts or ventilation of feelings that may arise.

Be attentive and calm:

Most doctors feel anxious when breaking bad news and it is worth spending sometime to eliminate any signal that may suggest our own anxieties. Maintain eye contact and show your attention. If the patient start to cry, try shifting your gaze because nobody likes to be watched while crying. This should howeve be done with sensitivity and must never send a signal that you do not really care about the patient's feelings.

Listening mode:

Silence and repetition of last few words that the patient has said, are two communication skills that will send across the message that you are listening well.

Availability:

If you have appointments to keep, give your patient a clear indication of your time constraints but make yourself available to the patient for all his queries and doubts, for the duration that you are with him or her.

Step-2: Patient perception:

The principle involved in this step is "before you tell, ask". Before you break the bad news to the patient try to ascertain as possible the patient's of his or her medical condition. Obtaining this information depends on your own communication style. As your patients responds to your questions take note of the language and vocabulary that he is using and be sure to use the same vocabulary in your sentences. This alignment as it helps you assess the gap between patient's expectations and actual medical condition. If the patient is in denial, try not to confront him in the first interview, as denial is an unconscious defence mechanism that facilitates coping.

Step-3: Invitation:

Although most patients want to know all about their illness but assumption towards that should be avoided. Obtaining overt permission respects the patient's right to know or not to know. Some examples to address this are: "Are you the kind of the person who likes to know all the details about what's going on?" "How much information would you like me to give you about your diagnosis and treatment?" , "Would you like me to give your details about what is going on or would you prefer I tell you about the treatments I am prescribing to you?"

Step-4: Knowledge:

Before you break bad news give your patient a warning of some sort to help him prepare for himself e.g. "Unfortunately I have some bad news to tell you Mr. X" or "I am sorry to have to tell you..."when giving your patient bad news, use the same language that he uses. This aligning is very important if you want to maintain a therapeutic relationship with the patient. Avoid scientific and technical language. Even the most well informed patients find technical terms difficult to comprehend in that state of emotional turnmoil. Give information in small bits and clarify whether he understands what you have said so far, e.g "Do you see what I mean" or "is this making sense so far". As emotions and reactions arise during the interview, acknowledge them and respond to them.

Step-5: Empathy:

For most doctors responding to our patients emotions is one of the most difficult parts while breaking the bad news. In our effort to alleviate our own discomfort it is tempting to withhold certain information or give a more hopeful pictures than I actually is. Although these tactics may help in short term they would seriously undermine all your efforts in the long run. It is much more useful and therapeutic to

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acknowledge the patient's emotions as they arise and address them. The technique that is most useful is termed as *empathic response*. In empathic response one needs to listen and identify the emotions or mix of emotions that the patient is experiencing and offer an acknowledgement for that. Identify the source of that particular emotion and then respond by showing that you understand the emotional expression of the patient. Combining the empathic response and the exploratory response and then validating the patient's feelings, reassure the patient that you understand the human side of the medical issue and that you have a respect for this feelings.

Step-6: Summarize:

Before the discussion ends, recapitulate the information in a short summary of all that has been discussed and give your patient an opportunity to voice any major concerns or questions.

Step-7: Plan of action:

You and your patient should go away from the interview with the clear plan for the next steps that need to be taken and the role you both would play, in the management of the issues.

B. Individualized disclosure model:

In this model the amount of information disclosed and the rate of its disclosure are tailored to the desires of the individual patient by the doctor patient negotiation. Together they will clarify what information the patient wants and then it will become the doctor's task to impart it in a way that the patient understands. This is an on-going and developing process. It implies a level of mutual trust and communication that will take time and effort to develop. The distinguishing feature of this model are that it takes time and skills which the busy physician may feel that he/she does not have its assumptions are supported by evidence. Due to its emphasis on consumerism and consensus, it has the capacity to maximize the quality of life for the patient. The underlying assumptions in this model are that peoples are different, it takes time to absorb and adjust with the bad news and partnership between the doctor and the patient for decision making is in the patient's best interest. Its *disadvantage* is that it is very time consuming process and it drains caregiver' emotional resources.

The *advantages* are that the amount of information given and rate of disclosure is tailored to needs of the individual and a supportive relationship with the doctor is established.

C. Full disclosure model:

This model involves giving full information to every patient as soon as it is known. It is argued that it promotes doctor-patient trust and communication and facilitates mutual support within the family unit. The underlying assumptions in this model are that the patient has a right to full information about himself and the doctor has an obligation to give it; all patients wants to know bad news about themselves and that patients themselves should decide what treatment is best for them.

The *disadvantages* of the model are that discussion of option in detail may frighten and confuse some patients, insisting of information may undermine defences e.g , denial which are otherwise important for the survival of the patient and lastly full information may have negative emotional consequences for some. The model holds some *advantages* as well such as promotion of doctor patient trust, family support and allowing time to put affairs in order, helping those who cope by finding out maximum information.

D. Paternalistic disclosure model:

This model implies that information about the patient's disease is the right of the doctor and he delivers the information in the 'sugar coating' to minimize the pain and distress of the patient. It also

involves the expression of sympathy and a sharing of emotions on the part of the doctor. It is not a recommended method anymore.

E. Non disclosure model:

This model is based on the view that under no circumstances should patients be informed that they have acquired a lethal disease and that deception should be used if necessary, on the basis that the patient needs protection from the terrible reality of terminal illness. This model has been traditionally be adopted as part of a paternalistic and nurturing attitude of doctors towards their patients. The underlying assumption in this model are that it is appropriate for a doctor to decide what is best for the patient; patients do not want to hear bad news and that patients need to be protected from bad news. This model has obvious disadvantages:

- ✓ the denial of opportunity to adjust
- ✓ the trust in doctor is undermined
- ✓ opportunities for helpful intervention are lost
- ✓ patient compliance is less likely
- ✓ patients may acquire wrong information that can lead to avoidance, isolation and perception of rejection
- ✓ There are chances that the patient loses his sense of control.

Advantages of this model are that it is easier and less time consuming for the doctor and suits those people who prefer not to know their condition. This model is fast falling out of favors and is now widely rejected by modern day doctors as well as patients and their families.

Major challenges in breaking bad news: How to overcome?

- ✓ We need to recognize that it takes time to break bad news. To impart the information to a person that he may have a cancer or AIDS is to inflict a major psychological trauma. No surgeon would think of operating without booking an operating theatre and setting aside sufficient time to do a job properly. The same should apply to all important communication between health professionals and the families we serve. We need to know whose lives are going to be affected by the information we possess, to decide who should be invited to meet us and where the meeting takes place. This means that someone makes genogram, (a family tree) which identifies each relevant person's in the patient's family. Having identified the key people, we must decide who the best person to talk with them is and whether they should be seen together separately.
- ✓ Life threatening illness can undermine the confidence and trust of us all and the process of revising one's internal model of the world is made easier if the issues are clear and if there is someone nearby who will keep us safe during the period of vulnerability. It follows that the members of the caring professions can do a great deal to help people through these psychosocial transitions. Accurate information is essential to planning; hence the reaction of relief that is expressed by many patients when they are told that they have cancer. It is easier to cope with the worst than to live in an unplanned state of uncertainty. The patient has a right to know the truth about an illness, but we must respect his/her right to monitor the amount of new and painful information that he/she can cope with at any given time. It is just as wrong to tell people too much, too soon, as it is to tell them too little, too late.

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- ✓ People will remember, for the rest of their lives, the details of the occasions when important news was broken. Even the pictures on the wall are important , and there is a world of difference between the doctor who adopts a relaxed and supported attitude in a pleasant home like atmosphere and the busy impersonal consultant who breaks bad news in a public ward, or in the sterile environment of a treatment room. The placing of chairs at the same level , and at an angle to each other so that human contact is possible and there are no desks and barriers between us, helps to create the conditions in which communication us possible.
- ✓ Before telling people what we think they need to know, we should find out what they already know about the situation and what their priorities are. If they use words like 'cancer' or 'death', we should check out that these words mean the same to them as they to do us. 'There are many kinds of cancers what do the word to mean to you? Have you seen anyone die? How do you view death? Open the door for positive reassurance and explanation. The doctors fail to solve issues of the patient and issues that are concerning them most.

Empathy amongst medical students:

The single thread that links all the above non pharmacological interventions is the demand on the doctor to empathise with the patient and the family. This urge in a doctor to experience the feelings of his patients and to gain a deeper understanding of their distress/ disease/ disability and then to communicate it to them is the most important part of the good doctor patient relationship. It builds a therapeutic bond between the two.

- ✓ Most medical students start their career in a medical college with a huge capacity to empathize. All that they have to learn is to communicate it effectively. The biomedical model with its emphasis on the disease, rather than the person experiencing it provides few opportunities to develop and use this skill. The medical students eager on performing well and attaining higher grades, are rewarded for their ability. To memorize anatomical and biochemical facts, causes of diseases and classification systems. Their ability to empathize or relate with the patients at a human level is not marked, rewarded or appreciated. Slowly but surely they start to focus more on acquiring knowledge, than to develop and polish their skills of empathy.
- ✓ The best time to learn how to empathize is to introduce it in your relationships with each other as medical students. The first step in this direction is to opt to study in a group rather than alone. Once you are part of group, try and feel for the reactions in a fellow student, who is struggling with language, or a concept; who fails in a class test, a sub stage or viva. By sitting next to someone who has failed, or is in pain, and think he or she is feeling, is an important exercise by which you can eventually empathize with patients. Let the person you are trying to empathise with his/her feelings. The best technique in this persuit is to share his/her silence. Sit quiet. Listen actively; let the person know, that you care and it is ok for him or her to share feelings with you. This effort on your part to empathise with your partners and colleagues in the first couple of year in the medical college will make you comfortable with your own world of emotions. It is an important ability in a human to stay in touch and be aware of one's own feelings of others and thus enhance the ability to empathise. During clinical years, try and sit with patients, even after you have taken the history and have completed the clinical examination. Encourage them to talk about how they feel in a reaction to their illness, hospitalization, and treatments being offered to

them. Share their fears, disappointments; sorrow without taking side of health professionals. Ask question about illness and treatment at home. This would be irrelevant but create bonding between you and the patients and helps you to have insight how patient think.

Mixed Anxiety and Depression:

Presenting complaints:

It may present initially with a history of two weeks or more of one or more physical symptoms such as fatigue and pain. Further inquiry will reveal depressed mood and feeling of fear, apprehension or a state of gloom.

Diagnostic features:

- Low or sad mood loss of interest or pleasure, inability to cope with routines/duties prominent anxiety or worry.
- Associated symptoms that are frequently present include disturbed sleep, poor concentration, expressed as forgetfulness, change in appetite, dryness of mouth, tremors, palpitations, dizziness and suicidal thoughts or acts.

Differential diagnosis:

If depression or anxiety is severe consider depressive disorder and anxiety disorder as independent conditions.

If hallucinations (hearing voices, seeing visions, or delusions (strange or unusual beliefs) are present consider acute psychotic disorder.

If excitement, elevated mood, rapid speech is present, consider bipolar affective disorder.

Management guidelines:

In case the diagnosis of anxiety and depression is made follow the steps as listed below:

I. Provide informational care:

Essential information for patient and family:

- ✓ Stress or worry has many physical and mental effects. The symptoms are real and understandable. They can be managed and relief is possible.
- ✓ These problems are not due to weakness and laziness; patients are trying their hardest. Do not blame the patient for not trying hard enough or consider him weak and timid. Do not repeatedly tell him to use 'will power' go on holidays, etc to get better.

II. Counseling:

Ask the patient to practice relaxation methods (progressive muscular relaxation, deep breathing exercises, visual imagery etc) to reduce physical symptoms. Tell the family to remind and encourage the patient to undertake the exercises and practice the recommendations.

- ✓ Ask about risk of suicide in explicit terms-can patient be sure of not acting on suicidal ideas?
- ✓ Plan short term activities which are relaxing and build up confidence in patients. Resume activities which are helpful in the past.
- ✓ Identify exaggerated worries or pessimistic thoughts. Discuss ways to challenge these negative thoughts.
- ✓ If physical symptoms are present, discuss link between physical symptoms and mental distress.(Reatttribution)

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- ✓ If tension related symptoms are prominent, advise relaxation method to relieve physical symptoms.

III. Medications:

- ✓ Consider antidepressant drugs if sad mood is prominent. In mixed anxiety and depression lower doses may be effective, e.g (antidepressant imipramine starting at 25mg at each night increasing to 150mg by the 15th days or fluoxetine 20mg per day)
- ✓ Explain how medications should be used and what to expect:
  - i. Medications must be taken every day.
  - ii. Improvements will build over 2 to 3 weeks.
  - iii. Mild side effects may occur that usually fade in 7-10 days, or become less disturbing. These may include dryness of mouth, constipation, excessive sweating.
- ✓ Check with the doctor before stopping medications
- ✓ Continue antidepressants for at least six months after the symptoms improve.

IV. Specialist consultation/referral:

If suicide risk is severe, consider urgent referral to the nearest psychiatric facility after admission. Refer the patient to the nearest psychiatric OPD if the patient does not respond to the management plan even after 6 weeks of treatment.

Panic disorder:

Presenting complaints:

These patient present in emergency with one or more physical symptoms such as chest pain, tightness, feeling of suffocation, dizziness, and fear of having 'heart attack'. Further inquiry shows the full pattern described

Diagnostic feature:

3-4 attacks of sudden onset of anxiety or fear in which there is a feeling of dread, impending disaster, accident as he/she is about to die. It often occur with PHYSICAL SYMPTOMS such as palpitations, chest pain, shocking feeling, churning stomach, dizziness, feelings of unreality, or fear of some disaster(losing control or going mad, heart attack and sudden death)

A typical panic attack begins suddenly builds rapidly, and may last only a few minutes. Symptoms start while the patient is at rest. It often leads to fear of another attack and avoidance of places where attacks have occurred. Patients may avoid exercise or other activities which produce physical sensation like panic.

Differential diagnosis:

- ✓ Many medical conditions may cause symptoms similar to panic attacks, such as coronary artery disease (CAD) and asthma. Rule these out with appropriate history such as onset of pain or breathlessness on effort, change in rhythm, rhonchi or crepitations on examination of the chest and typical chains in ECG. This exercise should not be repeated with each subsequent attack once the diagnosis of panic attack is established.
- ✓ If attacks occur only in specific feared situations, considered phobic disorders.
- ✓ If low or sad mood is also present, consider depression.

Management guidelines:

1. Provide informational care:
   - ✓ Essential information for patient and family
   - ✓ Panic is common and effective treatments are available.
   - ✓ Anxiety often produces frightening physical symptoms. Chest pain, dizziness or shortness of breath are not necessarily signs of heart disease, asthma or similar disorder none of the symptoms being experienced are dangerous or fatal. They are like a storm, that comes and then passes away, all you have to do is lie low. Similarly the symptoms of a panic attack are transient and always pass away.
   - ✓ Mental and physical anxiety reinforces each other. Concentrating on physical symptoms will increase fear.
   - ✓ Do not withdraw from or avoid situations where attacks have occurred; this will strengthen anxiety.
2. Counseling:
   - ✓ Counsel the patient and family to:
   - ✓ Concentrate on controlling anxiety not on medical worries.
   - ✓ Practice slow relaxed breathing. Controlled breathing will reduce physical symptoms.
   - ✓ Identify exaggerated fears which occur during panic (e.g. patient fears, he is having a heart attacks). Discuss ways to challenge these fears which occurs during panic e.g. the patient could tell himself "I m not having a heart attack. This is a panic attack and it will pass in a few minutes".
3. Medications:
   - ✓ Many patients with panic attacks will not need medications.
   - ✓ If attacks are frequent and severe if significant depression is present, Antidepressants may be helpful (e.g. imipramine 25 mg at night increasing upto 75-100 mg at night after 2 weeks).
   - ✓ For patients with infrequent and limited attacks occasional use of anti-anxiety medication may be helpful (lorazepm 1mg upto 3 times a day for 2 to 3weeks. But never more than 5 weeks.
   - ✓ Always tapered the dose in allowances of 1/4th of the dose every 5th day. Regular use of benzodiazepines may lead to dependence and is likely to result in the return of the symptoms when discontinued. Avoid unnecessary medical test or therapies.
4. Specialist consultation/ referral:
   - ✓ Consider a referral for consultation with psychiatrist, if severe attacks continue after the above treatment, for 4 weeks.
   - ✓ Avoid referral for medical consultation for exaggerated medical worries.

Drug abuse and tobacco use:

Drug abuse and smoking are very common trend among adolescents. Young adults and sometimes amongst medical students and health personnel.

Depending on their specific personalities and various other environmental factors, these people these people resort to drug abuse mainly for the following reasons.

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- ✓ An escape from painful reality and responsibility of adulthood.
- ✓ Peer pressures for identifying with their specific peer group.
- ✓ To avoid physically painful conditions, e.g. narcotic injections for relieving pain by a fracture.
- ✓ To see novelty and thrill.
- ✓ Various myths and misconceptions about drug such as "doing it once in a while does not make you an addict".
- ✓ To use drugs to copy or imitate an ideal or famous figure.
- ✓ Some drugs are hallucinogenic in nature, e.g. cannabis (charas), some are 'downers' e.g. alcohol, others are euphoric agents such as narcotics while others are stimulants such as tobacco, cocaine, amphetamine. These drugs may enhance sexual pleasure, improve stamina and performance.
- ✓ Stimulants abuse is a common among professionals and doctors and is used on the pretext that it helps them to be more protective and alert.

Tobacco abuse increase the risk of CAD and malignancy etc. IV drug increases the risk of hepatitis and AIDS.

The management of tobacco dependence and drug abuse is assessed on the following parameters:

Assess the cultural and social pressures that lead to the start and now leading to the abuse of tobacco or a drug.

Assess the patient's motivation:

Create an individualized plan for the patient that includes:

Detailed smoking history, assessment of degree of addiction to nicotine or the drug of abuse, compile a bio-psycho-social perspective of the patient smoking or abusing patterns, establish realistic expectations and a specific date to quit.

The physical symptoms of nicotine withdrawal subside within 1-3 weeks, but the psycho addiction lasts much longer.

Nicotine chewing gums and low tar cigarettes can be used as alternatives during the initial phase. The withdrawal state with stimulants, solvents and opiates may lasts for one to two weeks.

Patient should practice coping skills for high risk situations such as negative mood states, sudden boredom, eating drinking and social situations. They need to have a variety of behavior and coping skills including distraction, delay not giving in to the urge, deep breathing, escape positive statements, cognitive restructuring and recommitting to benefits of quitting.

Exercise and relaxation is very effective in nicotine withdrawal.

Unit 15

HISTORY & EXAMINATION

HISTORY TAKING

Introduction

Name.....s/o, d/o..... Age.....years, Sex..... Marital status.....

Religion..... Occupation..... Reg. no..... Bed no.....

D.O.A..... D.O.D.....

Address.....

Admission via OPD..... , Emergency....., Reference.....

Presenting complaints (In chronological order, in pt's own words)

1 .....

.....

2 .....

.....

3 .....

History of present illness

.....

.....

.....

.....

Systemic Inquiry (don't repeat same questions)

General	CVS
✓ Appetite	✓ Chest pain
✓ Wt.change	✓ Compression
✓ Sleep disturbance	✓ Breathlessness
✓ Energy	✓ Paroxysmal nocturnal dyspnea
✓ Lethargy	✓ Orthopnea
✓ Fatigue	✓ Feet swelling
✓ Fever	✓ Pain in legs on walking
Respiratory system	**GIT**
✓ Cough	✓ Nausea

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✓ Sputum ✓ Hemoptysis ✓ Breathlessness ✓ Wheeze ✓ Rhinitis ✓ Seasonal variation	✓ Vomiting ✓ Abdominal Pain ✓ Heart burn ✓ Difficulty in swallowing ✓ Dysphagia ✓ Altered bowel habits ✓ Bloody vomiting (haematemesis) ✓ Black tarry stools (malena) ✓ Yellow sclera (jaundice) ✓ Abdominal distension
Urinary System	**Nervous System**
✓ Pain ✓ Frequency ✓ Urgency while micturation ✓ Haematuria ✓ Anuria ✓ Polyuria ✓ Oliguria ✓ Nocturia ✓ Passage of gravel in urine ✓ Flank pain (nausea vomiting fever ✓ Burning discharge	✓ Weakness ✓ Numbness ✓ Headache ✓ Vomiting ✓ Giddiness ✓ Blackouts ✓ Fits ✓ Visual loss ✓ Diplopia ✓ Vertigo ✓ Altered conscious level ✓ Irrelevant talk
Locomotor System	**Skin**
✓ Joint pain ✓ Stiffness ✓ Swelling ✓ Restriction of movements	✓ Rash ✓ Itch ✓ Pigmentation ✓ Ulcers ✓ Patchy hair loss
Hematology	**Endocrinology**
✓ Purpuric rash ✓ Bleeding gums ✓ Leg ulcers	✓ Polyuria ✓ Polyphagia ✓ Polydypsia ✓ Sweating Heat/Cold Intolerance ✓ Wt.gain\ Loss ✓ Palpitations

Explain for any symptom found in the systemic review.....

.....

.....

Third party information *(Ideally from a relative living with the pt.)*

.....

.....

.....

Past History

Previous hospitalization ( ) Similar disease in the past ( )
TB ( ) Hepatitis ( ) Asthma ( ) Arthritis ( ) Jaundice ( ) DM ( )
H/O blood transfusion ( )

Detail if relevant

.....

.....

.....

Personal History

Pt's socioeconomic status.....
Dietary habits.....
Drug addiction.....
Smoking active/passive.....
Health of wife /husband/children.....
H/O foreign travel.....
Immunization.....
Allergy to anything.....

Occupational History *(Present & In the past)*

.....

.....

Family History

Similar disease in the family (dm (ihd (htn (Hepatitis (Arthritis (Stroke (tb) Malignancy (Deaths at early ages in
the family)

Menstrual History

Age at menarche..... Length of cycle..... Frequency..... Regularity ( )
Pain associated with menstruation (Dysmenorrhea) ( )
Pain during coitus (Dyspareunia) ( ) Age at menopause.....
Postmenopausal symptoms--- Hot flashes ( ) Postmenopausal bleeding ( ) / Discharge ( )

Treatment/ Drug History *(if indicated)*

.....

.....

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RESPIRATORY SYSTEM EXAMINATION

1. Introduction and Explain
2. Place the patient in a sitting position and ask whether he or she is comfortable.
3. Examine the sputum cup and comment on the sputum.
4. Exposure
5. Begins with the hands looking for the following signs:
   - ✓ Nails
   - ✓ Tremors,
   - ✓ Erythema,
   - ✓ Flapping Tremors : and asterixis (signs of carbon monoxide narcosis).
   - ✓ Cyanosis
   - ✓ Tar staining (the yellow 'nicotine' staining is actually due to tar).
6. Pulse: Examine the pulse for bounding pulse
7. BCG Scar on left Shoulder
8. Eyes: looking for pallor and evidence of Horner's syndrome.
9. Oral Cavity
10. Examine the patient from the foot end of the bed and comment as follows:
    - ✓ Whether the patient is breathless at rest.
    - ✓ On wasting, if any, in the infraclavicular region.
    - ✓ On diminished movement on the right or left side.
    - ✓ Count the respiratory rate.
11. Inspection of Chest : Respiratory Rate, Type of respiration, Any scar and visible pulsations
12. **Examine the neck:**
    - ✓ Comment on neck veins.
    - ✓ Check for cervical lymphadenopathy. From the back
    - ✓ Comment on the trachea: one small or no pillow allowed.Whether or not it is deviated.
    - ✓ The distance between the cricoid cartilage and suprasternal notch.
13. Palpation:
    - ✓ Trachea Position
    - ✓ Apex beat.
    - ✓ Chest expansion with hands and with tape
    - ✓ Percussion
    - ✓ Tactile Fremitis say 99. Vocal fremitus (tell the examiner that you would prefer to do vocal resonance because it gives the same information and is more reliable).
14. Percussion: Percuss over supraclavicular areas, clavicles, upper, middle and lower chest on both sides
    - ✓ Percuss for upper border of liver
    - ✓ Percuss for Dextrocardia
15. Auscultation: Use bell above clavicles
16. Vocal Resonance: Ask patient to say 99 while listening to chest with stethoscope
    - ✓ Over supraclavicular areas, upper, middle and lower chest on both sides -comment on breath sounds (whether vesicular or bronchial) and on adventitious sounds (wheeze, crackles or pleural rub). If crackles are heard, ask the patient to cough and then repeat auscultation. It is important to time the crackles to ascertain whether they occur in early, mid or late inspiration.
    - ✓ While auscultating the front of the chest, seize the opportunity to listen to the second pulmonary sound.

- ✓ Check for forced expiratory time (FET) if your diagnosis is chronic obstructive airways disease (COAD) by asking the patient to exhale forcefully alter full inspiration while you are listening over the trachea: if the patient takes more than 6 seconds, airway disease is indicated.

17. Remember to look for signs of middle lobe disease in the right axilla.
18. Ask the patient to sit forward:
19. Move Back : Keep the hand on the shoulders and Palpate Neck
20. Inspection and palpate any tender area on back
21. Measure Chest Expansion on 10th Rib level and measure range and symmetry of the movement
22. Percussion : Tactile/ Vocal Fremitis say 99 using palms of hands: Now I want to do what we call it Vocal Fremitis and what I want from you to say 99...OK
23. Then percuss the back
24. Diaphragmatic extursion: Deep breath in and out and hold it and you percuss and then take deep breath in and hold it and you percuss the base and it is 5 cm
25. Auscultation one point one breathing cycle
    Note DPI: Duration, Pitch, Intensity and then Type of sounds and any added sounds
26. During auscultation breath deeply through your mouth and Let me know if it is uncomfortable.
27. Vocal resonance on back
28. Pedal oedema
29. Say thanks to the patient and cover

CVS EXAMINATION

1. Introduction and Explain
2. Bed Angle 45
3. Exposure(be sensitive of the feelings of female patients)
4. General Inspection:
   - ✓ Dyspnoea
   - ✓ Cyanosis
   - ✓ Marfan's, Turner's, Down Syndrome
   - ✓ Rheumatological spondylitis (aortic regugitation)
   - ✓ Acromegaly.
5. Begins with the hands looking for the following signs:
   - ✓ Nails(Clubbing,Petechial Haemorrhages,Cyanosis),
   - ✓ Palm(Osler Nodes,Jainway Lesions)
   - ✓ Xanthomata
5. Pulse:
   - ✓ Rate (count for 15 s), rhythm, character, volume, condition of vessel wall
   - ✓ Lift the arm to feel for the collapsing pulse(Ask for pain in shoulder explain)
   - ✓ Feel the other radial pulse simultaneously
   - ✓ Look for radio-femoral delay
6. Comment on the scar at antecubital fossa (cardiac catheterization scars).
7. Blood Pressure(first by palpatory method then auscultatory method)

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- ✓ Sit down by bedside and perform

8. Eyes: Look at the eye for pallor, Argyll Robertson pupil, xanthelasmas, jandice.
9. Malar flush (Mitral Stenosis, Pulmonary Stenosis)
10. Oral Cavity: with flash of light
    - ✓ Hygeine, dental carries
    - ✓ Palate (high arched – Marfan's)
11. Look at the tongue for pallor, central cyanosis.
12. Examine the jugular venous pulse: comment on the wave form and height from the sternal angle. Check the abdominojugular reflux.
13. Comment carotid pulse character (first 3 finger pulp) and on any carotid pulsations (Corrigan's sign of aortic regurgitation).
14. Examine the precordium: comment on surgical scars (midline sternotomy scars, thoracotomy scars for mitral valvotomy may be missed under the female breast).
15. Feel the apex beat - position and character (show rib counting technique).
16. Feel for left parasternal heave and thrills at the apex and on either side of the sternum.
17. Aucultation:
    - ✓ Heart sounds
    - ✓ Murmurs (effect of respiration)
    - ✓ Position of patient
    - ✓ Left lateral position
    - ✓ Sitting forward (forced expiratoy apnoea)
    - ✓ Auscultate carotids for radiation and bruit
18. Listen to the heart, beginning from the apex: take care to palpate the right carotid pulse simultaneously so that the examiner notices that you are timing the various cardiac events.
19. Always comment on the first and second heart sounds. Mention any additional heart sounds.
20. If you do not hear the mid-diastolic murmur of mitral stenosis, make sure you listen to the apex in the left
21. Lateral position with the bell of the stethoscope.
22. If you hear a murmur at the apex, ensure that you get the patient to breathe in and out - the examiner will be observing whether or not you are listening for the variation in intensity with respiration.
23. If you hear a pansystolic murmur, listen at the axilla (mitral regurgitant murmurs are conducted to the axilla).
24. Using the diaphragm of your stethoscope, listen at the apex, below the sternum, along the left sternal edge, the second right intercostal space and the neck (for ejection systolic murmur of aortic stenosis, aortic sclerosis).
25. Request the patient to sit forward and listen with the diaphragm along the left sternal edge in the 3rd intercostal area with the patient's breath held in expiration for early diastolic murmur of aortic regurgitation.
26. Dynamic Auscultation:
    - ✓ Respiratory Phases
    - ✓ Valsalva

- ✓ Exercise (Isometric e.g. hand grip)
- ✓ Standing
- ✓ Squatting

27. Palpate neck for lymph nodes from the back
28. Tell the examiner that you would like to do the following:
    - ✓ Percus for Pleural effusion
    - ✓ Listen to lung bases for signs of cardiac failure.
    - ✓ Check for sacral and leg oedema.
29. Abdomen (lying flat – 1 pillow only)
30. Examine the liver (tender liver of cardiac failure for congestive cardiac failure, tricuspid regurgitation)
31. Percuss for ascites for right heart failure
32. Endocarditis: Splenomegaly, fundoscopy (Roth Spots), urine dipstick for haematuria, spinal tenderness.
33. Legs
    - ✓ Check the peripheral pulses .
    - ✓ Cyanosis, cold limbs, trophic changes, ulceration(Peripheral vascular disease)
    - ✓ Oedema
    - ✓ Xanthomata
    - ✓ Calf Tenderness
    - ✓ Clubbing of toes
34. Say thanks to the patient and cover

GIT EXAMINATION

EXAMINATION OF THE ABDOMEN

1. Ensure the patient is lying flat (remove any extra pillows, if present, with the permission of the patient); the hands should lie by the patient's side with the abdomen exposed/from the inframammary region to just above the genitalia.
Do not expose the genitalia.
2. Begin with the hands, looking for the following signs:
    - ✓ Clubbing, leukonychia (white chalky nails)
    - ✓ Palmar erythema.
    - ✓ Dupuytren's contracture (feel for thickening of the fascia)
    - ✓ Hepatic flap.
3. Examine the arms: look for arteriovenous fistula, haemodialysis catheters, spider naevi.
4. Comment on the skin:
    - ✓ Pigmentation
    - ✓ Scratch marks.

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5. Examine the following:
   - ✓ Supraclavicular and cervical lymph nodes.
   - ✓ Tongue for pallor.
   - ✓ Eyes for anaemia, jaundice, xanthelasma.
   - ✓ Upper chest and face for spider naevi.
   - ✓ Axilla for hair loss, acanthosis nigricans.
   - ✓ Breast for gynaecomastia.
6. Inspect the abdomen, looking for the following signs:
   - ✓ Movements
   - ✓ Any obvious mass
   - ✓ Visible veins (check direction of flow, which is usually away from the umbilicus)
   - ✓ Visible peristalsis
   - ✓ Hernial orifices (ask the patient to cough at this stage)
   - ✓ Expansile pulsations of aortic aneurysm
7. Ask the patient whether the abdomen is sore at any part.

Command: Is there any pain in your tummy, Please let me know if it is painful

8. Palpation: kneel on the floor or sit on a chair before you begin palpation. At all times look at the patient's face to check whether he or she winces in pain. Begin with superficial pain and begin in the least tender area. Palpate in all the quadrants (remember that there are four quadrants).
9. Palpate:
   - ✓ For mass - determine its characteristics.

   Command: Can you take a deep breath in and out for me please
   - ✓ Liver (percuss for upper border using heavy percussion, for lower border using light percussion).
   - ✓ Kidneys (bimanual palpation, demonstrate ballottement).
   - ✓ Groin for lymph nodes.
   - ✓ Check hernial orifices.
   - ✓ Test for expansile pulsation of an aortic aneurysm.
10. Percuss, looking for shifting dullness (at this stage, when the patient is lying on his or her right side, seize the opportunity to examine for a small spleen and for pitting oedema over the sacral region). Remember that abdominal percussion should follow adequate inspection and percussion.
11. Auscultate:
   - ✓ Over an enlarged liver for bruit.
   - ✓ Over a suspected aortic aneurysm.
   - ✓ For bowel sounds.
   - ✓ Ask the patient to sit forward: Go on back and do palpate for
     - Cervical lymphadenopathy
     - Sacral Oedema
     - Auscultate for Renal Bruit
12. Tell the examiner that you would like to perform a rectal examination and examine the external genitalia.
13. Examine the legs for oedema.
14. Cover the patient and say thanks

CNS EXAMINATION

Examination of the cranial nerves

First cranial nerve

1. Ask the patient, 'Have you noticed any change in your sense of smell recently?' 'Can you differentiate between the odour of tea, coffee and bananas?'.
2. If the examiner requires you to test the sense of smell, use an odour that can be readily identified, such as soap or clove oil. If the patient has frequent nasal trouble, the value of this examination is limited.

Second cranial nerve

1. First check visual acuity with a pocket Snellen's chart and finger counting.
2. Make sure that the patient wears her spectacles should she use them, as one is not concerned with refractive errors.
3. Check visual fields with a white hat pin (10 mm in diameter); your instructions to the patient should be clear and precise.

Smaller hat pins (5 mm in diameter) are used for detecting small scotomata. Red hat pins, for reasons that are not clear, are useful in the detection of pregeniculate lesions and are therefore useful in compression of the optic nerve, optic chiasm or optic tract.

4. Comment on the pupils (size, shape or inequality) and test their reaction to light (direct and indirect reaction) and to accommodation. The popular acronym PERRLA (pupils equal, round and reactive to light and accommodation) is a convenient description of normal pupillomotor function.
5. Examine the fundus in a definite sequence: retina, retinal vessels, optic nerve and macula.

Third, fourth and sixth cranial nerves

1. Test eye movements:
   - ✓ Remember to ask the patient whether she sees a double image - this is the most sensitive sign of defective eye movement and may be present even when there is no apparent weakness of extraocular muscle or an abnormality of gaze.
   - ✓ Saccadic movements are tested by asking the patient to look voluntarily to the right and left and up and down. Note whether these movements are carried out rapidly to the extremes of gaze.
   - ✓ Pursuit movements are examined by asking the patient to follow an object moved to the right and left and up and down.
   - ✓ Note whether these movements are carried out smoothly without interruption.
   - ✓ Remember to comment on nystagmus. Nystagmus is a repetitive drift of the eyeball away from the point of fixation, followed by a fast corrective movement towards it.
   - ✓ Comment on ptosis if present (seen in third nerve palsy).

Fifth cranial nerve

1. Test the masseters - 'Clench your teeth' - taking care to palpate the muscles.
2. Test the pterygoids - 'Open your mouth' - and note if the jaw deviates to the side of the lesion.
3. Test corneal (not conjunctival) sensation by touching a wisp of cotton wool to the cornea while the patient looks upward and away from the examiner.
4. Test facial sensation: keep in mind that this nerve supplies not only the face but also the anterior half of the scalp. Impairment of sensation limited to the face only is usually psychogenic in origin.

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5. Test jaw jerk: with the mouth half open, place your thumb over the patient's chin and lightly tap on the thumb. A mild jaw jerk or absent jerk is seen in normal individuals. In upper motor neuron lesions above the cervical cord, the jaw will manifest a marked jerk with this procedure.

Seventh cranial nerve

Remember that the facial nerve is a motor nerve.

1. Test the lower half of the face:
   - ✓ Ask the patient, 'Show me your teeth'.
   - ✓ Note the nasiolabial fold, which often disappears in mild facial palsy.
2. Test the upper half of the face:
   - ✓ Ask the patient, 'Screw your eyes tightly shut and don't let me open them'.
   - ✓ Have the patient wrinkle his or her forehead and note the movement of the muscles of the forehead.
   - ✓ Note. Taste may be lost on the anterior two thirds of the tongue, but this is not usually tested.

Eighth cranial nerve

I. Test by bringing a watch from beyond auditory acuity into the zone of hearing.

2. Occlude each external auditory meatus with your finger and whisper short phrases, asking the patient to repeat them.

3. Perform Rinne's and Weber's tests (use a tuning fork with a frequency of 256 or 512 cycles per second). Normally air conduction is better than bone conduction.

4. Rinne's test: in obstructive deafness, bone conduction is better. In nerve deafness the normal relations are kept, i.e. air conduction is greater than bone conduction in the deaf ear.

5. Weber's test: if the base of the tuning fork is placed on the middle of the forehead of a person with an obstructive deafness, he or she will hear it better in the deaf ear; with a nerve deafness, the fork will be heard better in the normal ear.

Ninth and tenth cranial nerves

1. Ask the patient 'Open your mouth and say "aah" '; observe the soft palate with a torch (the soft palate is pulled to the normal side on saying 'aah').

2. Tell the examiner that you would like to check gag reflex. An absence of gag reflex is significant only if it is unilateral.

Eleventh cranial nerves

1. Ask the patient, 'Shrug your shoulders', and try to push them down simul-taneously (this tests the trapezii muscles).

2. Test the sternomastoids by the patient's ability to resist lateral movement of the neck. Keep in mind that one rotates the head to the right by use of the /eft sternomastoid muscle.

Twelfth cranial nerve

1. Ask the patient, 'Open your mouth'; comment on fasciculations of the tongue while in the mouth. Comment on wasting.

2. Ask the patient, 'Stick your tongue out' (it deviates to the side of the lesion). Slight deviation of the tongue can be disregarded.

NEUROLOGCAL EXAMINATION OF THE PATIENT'S UPPER LIMBS:

1. Introduce yourself to the patient and ask him to take his top off so that both his arms are well exposed. If the patient is female, cover her breasts with suitable clothing so that she is decent.

2. Comment on wasting, tremors, fasciculations.

3. Assess tone: 'Let your arms go loose and let me move them for you'.

. Flex and extend wrists passively - cogwheel rigidity is elicited by this method.

. Flex and extend at the elbows, pronate and supinate at the forearm - lead-pipe rigidity and clasp-knife spasticity is elicited by these methods.

4. Test power: 'I am going to test the strength of the muscles of your arms'.

- ✓ Tell the patient, 'Hold your arms stretched out in front of you and then close your eyes'. Observe for drift, action tremor.
- ✓ Shoulder abduction: 'Hold your arms outwards at your sides (like this) and keep them up; don't let me stop you'. Chief movers are the deltoids, C5. (Note. Supraspinatus is responsible for the initiation of abduction and for the first 60 degrees of this movement. However, this method of testing only assesses the power of the deltoids.)
- ✓ Shoulder adduction: 'Push your arms in towards you and don't let me stop you'. Chief movers are the pectoral muscles, C6-8.
- ✓ Elbow flexion: 'Bend your elbows and pull me towards you; don't let me stop you'. Chief mover is the biceps, C5.
- ✓ Elbow extension: 'Straighten your elbows
- ✓ Wrist extension: 'Clench your fist and cock your wrists up; don't let me stop you'. Chief mover is C7.
- ✓ Wrist flexion: 'Now push the other way'. Chief mover is C7.
- ✓ Finger abduction: 'Spread your fingers wide apart and don't let me push them together'. Chief movers are the dorsal interossei, TI (ulnar nerve). **Note.** Dorsal interossei abduct: mnemonic, DAB.
- ✓ Finger adduction: 'Hold this piece of paper between your fingers and don't let ine snatch it away'. Chief movers are the palmar interossei, TI (ulnar nerve). **Note.** Palmar interossei adduct: mnemonic, PAD.
- ✓ Thumb abduction: 'Hold your palms facing the ceiling and now point your thumb towards the ceiling; don't let me stop you'. Chief mover is the abductor pollicis brevis, C8, TI (median nerve).
- ✓ Flexion of fingers: 'Grip these two fingers of mine tightly and don't let them go'. Chief movers are the long and short flexors of the fingers, C8.

Note.

- ✓ The median nerve supplies the lateral two lumbricals, opponens pollicis, abductor pollicis brevis, flexor pollicis brevis: mnemonic, LOAF.
- ✓ The ulnar nerve supplies all other small muscles of the hand.
- ✓ The lumbricals are responsible for flexion at the metacarpophalangeal joint when the interphalangeal joints are in extension.

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Power is graded from 0 to 5:

0: Absence of movement.
1: Flicker of movement on voluntary contraction.
2: Movement present when gravity is eliminated.
3: Movement against gravity but not against resistance.
4: Movement against resistance but not full strength.
5: Normal power.

5. Test deep tendon reflexes:

- ✓ Biceps jerk, C5, C6.
- ✓ Triceps, C7.
- ✓ Supinator, C5, C6.

Note.

- ➢ If the reflexes are absent, test after reinforcement - ask the patient to clench his or her teeth.

Inversion of the supinator reflex: When the supinator jerk is elicited the normal response is a slight flexion of the fingers, contraction of the brachioradialis and flexion at the elbow joint. The jerk is said to be 'inverted' when finger flexion is the sole response, with contraction of the brachioradialis and elbow flexion being absent. There is associated absence of the biceps jerk and exaggeration of the triceps jerk. The inverted jerk indicates a lower motor neuron lesion at the fifth cervical level and an upper motor neuron lesion below this level. It could be caused by cervical spondylosis, trauma to the cervical cord, spinal cord tumours at this level and syringomyelia.

6. Finger reflexes

- ✓ **Hoffmann's sign**. The examiner holds the patient's wrist in the horizontal pronated position with the fingers and wrists relaxed.
- ✓ Then the distal phalanx of the patient's middle finger is forcibly flexed. Normally no reflex occurs unless the patient is under emotional tension.
- ✓ In upper motor neuron lesions, the patient's thumb undergoes a quick flexion adduction-opposition movement while the other fingers move in flexion-adduction. This response is labelled as a 'positive' Hoffmann's sign.
- ✓ **Wartenberg's sign**. The patient places his or her hand in partial supination resting on a table with the fingers slightly flexed. Then the examiner places his/her middle and index fingers on the volar surface of the patient's tour fingers and taps his/her own fingers briskly with the tendon hammer. The response is one of flexion of the patient's four fingers and the distal phalanx of the thumb.
- ✓ **Mayer's sign**. With the patient's thumb abducted and the hand relaxed, the proximal phalanx of the middle finger is forcibly flexed towards the palm. Normally the thumb adducts. In upper motor neuron lesions the thumb usually remains in the position of abduction.

7. Test coordination

- ✓ Finger-nose-finger test: 'Touch your nose with your index finger and now touch my finger'.
- ✓ Rapid alternating movement of one hand over the other.

8. Test sensation

- ✓ Light touch: use cotton wool and check each dermatome.

- ✓ Pinprick: demonstrate first the sharp end and then the blunt end on the sternum; then check each dermatome for sharp or blunt sensation with the eyes closed.
- ✓ Joint position sense: check in the distal interphalangeal joint of the thumb.
- ✓ Vibration sense: use a tuning fork of 128 Hz/sec.
- ✓ First test on the sternum so that the patient can recognize the vibration and then check over the fingers moving proximally if the vibration sense is absent distally. Pallaesthesia is the ability to perceive the presence of vibration when an oscillating tuning fork is placed over certain bony prominences. Loss of vibratory perception is referred to as pallanaesthesia.

Remember:

- ✓ Joint sense and vibration sense are carried in the dorsal columns.
- ✓ Pain and temperature are carried in the lateral spinothalamic tracts.
- ✓ Light touch is carried in both the above tracts.

NEUROLOGICAL EXAMINATION OF THE PATIENT'S LOWER LIMBS:

1. Introduce yourself and then ensure that the lower limbs are well exposed. It is important to ensure that the patient is decent -cover the genital area with a towel or any suitable clothing.

2. Inspect for wasting, fasciculations (tap the muscles of the leg and thigh to elicit fasciculations if not seen).

3. Assess tone:

- ✓ Ask the patient, 'Let your leg go loose and lax, and let me move it for you'; then passively flex and extend the leg at the knee and hip.
- ✓ Roll the extended leg, feeling for resistance.
- ✓ Put your hand behind the knee and pull it upwards, observing the toot to check whether or not it flops.
- ✓ If there is spasticity or increased tone, then test for ankle clonus and patellar clonus.

Patellar clonus: With the patient in the supine position, grasp the upper edge of the patella between the thumb and index finger and apply a quick constant pressure in a downward direction. Avoid prolonging this manoeuvre as it is often painful to the patient. In upper motor neuron lesions the patella may manifest a few jerks (unsustained clonus) or a constant jerking as long as the pressure is applied (sustained clonus).

Ankle clonus: Ensure that the patient's knee is semi-flexed and the foot relaxed. The toot is suddenly pushed dorsally with moderate force and held there. In upper motor neuron lesions the posterior muscles of the leg will enter into a persistent contraction.

4. Test power (begin at the hips): 'I am going to test the strength of the muscles of your legs'.

- ✓ Hip flexion: 'Lift your leg straight up and keep it there; don't let me stop you'. Chief mover is iliopsoas LI, L2.
- ✓ Hip extension: 'Push your leg downwards into your bed and don't let me stop you'. Chief movers are glutei, L4, L5.

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- ✓ Hip adduction: 'Push your thigh inwards against my hand'. Chief movers are adductors of the thigh, L2-4.
- ✓ Knee flexion: 'Bend your knee and pull your heel towards you; don't let me stop you'. Chief movers are the hamstrings, L5, S I.
- ✓ Knee extension: 'Straighten your knee and don't let me stop you'. Chief movers are quadriceps, L3, L4.
- ✓ Plantar flexion of the ankle: 'Push your foot downwards against my hand'. Chief mover is the gastrocnemius, S 1.
- ✓ Dorsiflexion of the ankle: 'Move your foot up and don't let me stop you'. Chief movers are the tibialis anterior and long extensors, L4, L5.
- ✓ Inversion of the foot: 'Push your foot inwards against my hand'. Chief movers are tibialis anterior and posterior, L4.
- ✓ Eversion of the foot: 'Push your foot outwards against my hand'. Chief movers are the peronei, S 1.
- ✓ Extension of the great toe: 'Pull your toe upwards and don't let me stop you'. Chief mover is the extensor hallucis longus, L5.

5. Test the plantar response: 'I am going to tickle the bottom of your foot'; use an orange stick to stimulate the outer portion of the sole and then across the ball to the base of the big toe. Always describe the response as either downgoing or upgoing. Normally the response is downgoing, i.e. all the toes flex towards the plantar surface. Upgoing plantars or the Babinski response is a feature of upper motor neuron lesions where the four small toes fan and turn towards the sole while the big toe extends dorsally. There is associated slight flexion of the hip and knee. The contraction of the tensor fasciae lata is referred to as Brissaud's reflex and is a part of the spinal defence reflex mechanism. Other responses to plantar stimulation include: (a) quick avoidance response; (b) the grasp reflex; and (c) the support reaction. Remember that if the feet are cold (when outside the bedclothes for long) the response may be equivocal.

6. Test deep tendon reflexes

- ✓ Knee jerk, L4.
- ✓ Ankle jerk, S 1. In the elderly, the plantar strike technique is said to be more reliable than the tendon-striking method for eliciting ankle jerks. The plantar strike technique of eliciting ankle jerks is as follows:
- ✓ the patient's legs are side by side and the foot is passively dorsiflexed; the reflex hammer strikes the examiner's own fingers, which are placed over the plantar surface.
- ✓ When the reflexes are absent, reinforce by asking the patient to pull outwards his or her clasped hands (Jendrassik manoeuvre). Do not tie your hands into a knot while testing the left ankle jerk from the patient's right-hand side. Avoid jabbing the patient while eliciting reflexes.

Deep tendon reflexes grading system:

0 no response, abnormal.
1+ slight but definitely present response which may be normal or abnormal.
2+ brisk response, normal.
3+ very brisk response which may be normal or abnormal.
4+ a tap elicits clonus, abnormal.

Asymmetry of reflexes suggests abnormality.

7. Test coordination

Heel-shin test: Have the patient place the heel of one foot upon the knee of the opposite leg, and then move the heel downwards along the tibia. In a positive test, the patient has difficulty placing or holding the heel on the opposite knee or cannot keep the heel firmly on the tibia as the heel is moved downwards.

8. Test sensation

- ✓ Avoid testing in a given rhythm where the patient can expect to be stimulated at a given time. Always compare sensory responses in different areas of the same side of the body, as well as the two sides of the body.
- ✓ Light touch.
- ✓ Pinprick: test irregularly with the pin-point and pin-head, asking the patient whether the perceived sensation is sharp or blunt.
- ✓ Joint position sense: hold the lateral aspect of the patient's big toe (not the dorsum of the toe) while eliciting this and move the toe gently up and down. The examiner's fingers should not rub against the skin of the adjoining toe during this test. Also, the joint should not be put in the extreme position of flexion during the test.
- ✓ Vibration sense.

Note. When there is weakness of the limbs, tell the examiner that you would like to check sensation in the sacral area.

9. Romberg's test: 'Please stand up with your legs together and now close your eyes'. Take care to protect the patient if he or she sways or tends to fall. A positive test result is shown by pronounced swaying of the trunk. Sometimes functional cases will sway without having a true Romberg. This may be proved by diverting the attention of the patient by instituting the finger-nose test at the same time as Romberg is being tested. In functional cases the 'rombergism' will usually disappear.

10. Cheek gait:

If the heel-shin test is affected, then test tandem walking (asking the patient to walk along a straight line with one heel in front of the other foot). Candidates frequently forget to check the gait when asked to examine the legs.

[redacted] THYROID EXAMINATION

1. Inspection of the patient:

- ✓ Does he/she seem abnormally hyper- or hypoactive?
- ✓ Does he/she appear sweaty?
- ✓ What condition is his skin and hair?
- ✓ Does his voice sound normal?

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✓ Report any abnormalities to the examiner

2. A dysfunctioning thyroid gland may give stigmata of disease in many places, so as always, it is best to start with the hands. You should first feel the hands for any sweating. Look for any tremor – placing a piece of paper on the backs of the patient's outstretched hands may show this. Check the nails for any thyroid acropatchy – similar to clubbing, or onycholysis – where the nail comes away from the nail bed. You should also observe for any palmar erythema which may occur in hyperthyroidism.

3. Next feel the pulse. It may be tachy or bradycardiac if a thyroid condition is present.

4. Now move onto the neck. Observe it as a whole but pay particular attention to the area of the thyroid gland. You should look from the front and the side looking for any obvious abnormalities, scars or swellings.

5. Hand the patient a glass of water and observe them as they take a drink. Watch the movement of any swellings as they drink as this can help to differentiate between different causes.

6. Next you should feel the gland. The approach is from behind so always tell the patient what you will be doing and that you will be behind them. Warn them again the moment before you actually touch their neck.

7. Palpate the entire length of both lobes of the gland as well as the isthmus. Note any swellings or abnormal lumps. You should note the shape and consistency of any lumps as well as whether they are tender or mobile. You should also examine while the patient drinks to assess whether the lump moves with swallowing.

8. Whilst still behind the patient, take the opportunity to examine the cervical lymph nodes. You should also examine the eyes from behind and above to look for any exophthalmos – another sign of hyperthyroidism.

9. Finally auscultate the thyroid. A bruit, a sign of increased blood flow, may be heard in hyperthyroidism.

10. Thank your patient and report your findings to the examiner.

Symptoms and Physical Signs of Hyperthyroidism		Symptoms and Physical Signs of Hypothyroidism	
Symptoms	**Signs**	**Symptoms**	**Signs**
Heat intolerance	Tachycardia	Cold intolerance	Delayed relaxation of deep tendon reflexes
Diarrhea	Atrial fibrillation	Constipation	Dry skin
Emotional lability	Smooth skin, moist, warm palms	Lethargy	Myxedematous skin changes (generalized)
Poor concentration	Tremors	Decrease vigor	Hoarseness
Nervousness	Onycholysis	Arthralgia	Mental clouding
Weakness, fatiguability	Lymphadenopathy	Dry skin	Depression
	Proximal muscle weakness		

Unit 16

IMPORTANT RADIOLOGICAL SIGNS

Apple Core lesion —signifies annular carcinomas of the colon—looks like an apple core or napkin ring due to circumferential narrowing of the lumen, noted on contrast studies.

Bamboo Spine —fused spinal segments with their syndesmophytes look, on radiographs, similar to bamboo stalks—classically associated with ankylosing spondylitis.

Bird's Beak— noted on Upper GI with contrast, a dilated upper/middle esophagus with an abrupt taper to exceptionally narrowed lumen, typical of achalasia.

Boot-shaped Heart —due to RVH, the LV is lifted above the edge of the diaphragm, forming the "toe" of the boot. Classic for Tetralogy of Fallot.

Bat's Wing/Butterfly —this appearance on CXR is classically associated with CHF and resultant pulmonary edema.

Cobblestone appearance— this sign is produced on barium studies due to ulcerative pockets, usually in the terminal ileum, indicative of Crohn's.

Codman's Triangle —a triangle on plain film of extremities that signifies reactive bone, classically associated with osteosarcoma, or other infectious/hemorrhagic process that causes periosteal elevation.

Coin lesion— solitary pulmonary nodule; may be cancer or granuloma.

Cookie Cutter lesions— metastatic lesions to bone cortex, or Paget's.

Crescent sign— classic sign of avascular necrosis, femoral head.

Egg-on-a-string— a large, ovoid-shaped heart on newborn CXR, classically signifying complete transposition of the great vessels with intact ventricular septum.

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Ground glass— a "white-out" on CXR, usually PCP pneumonia or ARDS.

Hampton's Hump— a peripheral triangle, usually near pleural edges, classically PE.

Honeycomb lung— used to describe any pathologic process that causes radiographic appearance of multiple small, thick-walled cystic spaces; e.g. pulmonary fibrosis.

Lead pipe sign— classic narrowing of bowel lumen, with loss of haustra—UC.

Napkin Ring sign— see Apple core lesion above; pathology identical, but lumen more narrowed.

Onion-skinning — layered look of periosteum in Ewing's Sarcoma.

Rachitic Rosary — this is a "string of beads" appearance on x-ray, a thickening of costochondral margins that is noted in Ricketts(Vit. D Deficiency).

Sail sign —fat pad noted on plain film, indicative of shoulder disclocation.

Scotty dog(collar) —on posterior oblique, the lumbar vertebrae look like a Scottish terrier. The neck is the pars interarticularis, and a break(a collar) noted there indicates spondylolysis.

String sign —thin, slightly irregular shadow in narrowed lumen of ileum, suggestive of Crohn's.

Silhouette sign —obliteration of cardiovascular silhouette due to adjacent disease, ie pneumonia, TB, etc.

Stepladder appearance —distended bowel loops, often indicative of obstruction, usually SBO.

Sunburst appearance—"clouds, clumps, and consolidated rays" of tissue emanating from bone cortex, or within bony structures, indicative of osteosarcoma.

Thumb(print) sign —on lateral c-spine, an enlarged epiglottis appears as a "thumb"—epiglottitis.

Westermark's sign —abrupt end to a pulmonary vessel, signifying oligemia or PE.

SECRETS of Signs & Symptoms and their Causes

1. JOINT PAIN

   CAUSES

   i. Rheumatoid arthritis
   ii. Osteoarthritis
   iii. Septic arthritis
   iv. Gouty arthritis
   v. Tuberculous arthritis
   vi. Ankylosing arthritis
   vii. Psoriatic arthritis
   viii. Reactive arthritis
   ix. Rheumatic fever
   x. Reiter disease
   xi. Enteropathic arthritis
   xii. Behcet disease
   xiii. Pyrophosphate arthropathy
   xiv. Juvenile arthritis e.g Still's disease
   xv. Polymyalgia rheumatic
   xvi. Systemic sclerosis
   xvii. Polymyositis/ dermatomysitis

2. Vertigo

   CAUSES

   i. Vertebrobasilar insufficiency
   ii. Meniere disease
   iii. Acute labyrinthitis
   iv. Psychogenic vertigo
   v. Acoustic neuroma (Schwannoma)
   vi. Cerebellopontine tumours
   vii. Chronic Otitis media
   viii. Cervical spondylosis
   ix. Benign positional vertigo
   x. Ototoxic drugs (aminoglycosides, some diuretics)
   xi. Acute cerebellar lesion
   xii. Alcohol intoxication
   xiii. Anti epilepsy drug intoxication
   xiv. Multiple sclerosis

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3. Syncope

CAUSES

i. Carotid sinus syncope
ii. Stokes adams attacks
iii. Postural hypotension
iv. Hysterical fainting
v. Vasovagal syncope (neurocardiogenic, vasodepressor, simple faints)
vi. Transient ischemic attack
vii. Seizure disorder
viii. Aortic stenosis
ix. Prolapsed mitral valve
x. Pulmonary HTN
xi. AV block
xii. Atrial myxoma
xiii. Hypoglycemia
xiv. Hypovolemia
xv. Ventricular tachycardia
xvi. Supraventricular tachycardia
xvii. Sick sinus syndrome
xviii. MI
xix. Hypertrophic obstructive cardiomyopathy
xx. Stuck up prosthetic valve

4. Headache

CAUSES

i. Hypertension
ii. Migraine
iii. Cluster headache
iv. Headache due to raised intracranial pressure
v. Giant cell arteritis (temporal arteritis)
vi. Meningitis
vii. Subarachnoid haemorrhage
viii. Tension headache
ix. Headache due to eye diseases e.g referred pain due to errors of refraction
x. Headache due to ear diseases
xi. Headache due to sinusitis
xii. Psychogenic headache
xiii. Drug intake e.g nitroglycerin

5. Hematuria

CAUSES

i. Renal stones
ii. Pyelonephritis
iii. Renal tumors
iv. Renal infarction
v. Renal tuberculous
vi. Berger disease
vii. Cystitis
viii. Vesical calculus
ix. Vesical tumours
x. Urethritis
xi. Prostitis
xii. Thrombocytopenia purpura
xiii. Anticoagulant therapy
xiv. Renal cysts (polycystic kidney)
xv. Interstitial nephritis
xvi. Post streptococcal glomerulonephritis
xvii. Membranoproliferative glomerulonephritis
xviii. IgA nephropathy

6. Polyuria

CAUSES

i. DM
ii. Hypercalcemia
iii. Diabetes inspidus
iv. Diuretic therapy
v. Compulsive water drinking

7. Chest Pain

CAUSES

i. Angina pectoris
ii. Pericarditis
iii. MI
iv. Pneumonia
v. Pneumothorax
vi. Pulmonary embolism
vii. Musculoskeletal chest pain
viii. Pleurisy
ix. Esophageal spasm
x. Reflux Esophagitis
xi. Dissecting aneurysm

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xii. Aortic stenosis
xiii. Hypertrophic cardiomyopathy
xiv. Aortic dissection
xv. Peptic ulcer
xvi. Costochondritis
xvii. Herpes zoster

8. Breathlessness
CAUSES
i. Bronchial asthma
ii. Chronic bronchitis
iii. Pneumonia
iv. Pneumothorax
v. Pleural effusion
vi. Pulmonary embolism
vii. Pulmonary fibrosis
viii. Congestive heart failure
ix. Acute pulmonary edema
x. Diabetic ketoacidosis
xi. Hyperventilation syndrome

9. Hemoptysis
CAUSES
i. Pulmonary TB
ii. Pulmonary Infarction
iii. Bronchiectasia
iv. Lung cancer
v. Lung abscess
vi. Bronchogenic adenoma
vii. Mitral stenosis
viii. Thrombocytopenia
ix. Clotting disorders
x. Bronchitis
xi. Goodpasteur syndrome
xii. Wegner syndrome

10. Jaundice
CAUSES
a. Hemolytic anemias (Pre-hepatic Jaundice)
i. Auto immune hemolytic anemia
ii. Thalasemia
iii. G6PD deficiency
iv. Blood transfusion reactions
b. Hepatic

i. Viral hepatitis
ii. Toxic hepatitis (toxic drugs or chemicals)
iii. Infiltrative diseases (Cirrhosis liver, Wilson disease, Hemochromatosis)
iv. Congenital hyperbilirubinemia (Gilbert disease, Dubin Johnson syndrome, Rotor syndrome)

c. Post hepatic (Obstructive)
i. Choledocholithiasis
ii. Cholangitis and cholestasis
iii. Malignancies: Carcinoma head of the pancreas, carcinoma Ampulla of Vater, Carcinoma common bile duct

11. Constipation
CAUSES
i. Irritable bowel disease
ii. Hypothyroidism
iii. Chronic amoebiasis
iv. Diverticulitis
v. Tumors of rectum
vi. Tumors of colon
vii. Psychiatric problems e.g depression and anxiety
viii. Low roughage diet
ix. Physical inactivity
x. Antacids (aluminium containing)
xi. Opiates
xii. Anti depressants

12. Diarrhoea
CAUSES
i. Amoebiasis
ii. Giardiasis
iii. Bacillary dysentery
iv. Food poisoning due to Salmonella
v. Cholera
vi. Due to E.Coli
vii. Intestinal tuberculosis
viii. Due to Rotavirus, Enteroviruses
ix. IBD
x. Inflammatory bowel disease e.g Ulcerative Colitis and Crohn disease
xi. Celiac disease
xii. Lactase deficiency
xiii. Chronic pancreatitis

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xiv. Tropical sprue
xv. Hyperthyroidism
xvi. Addison disease
xvii. Colonic carcinoma
xviii. Villous adenoma
xix. Carcinoid tumor
xx. Antibiotics
xxi. Antacid containing Mg
xxii. Diverticulitis
xxiii. Traveller's diarrhea
xxiv. Roundworm, tapeworm and hookworm infestations
xxv. Psychogenic diarrhoea

13. Dyspepsia

CAUSES

i. Gastric ulcer
ii. Duodenal ulcer
iii. Irritable bowel syndrome
iv. Chronic cholecystitis
v. Chronic pancreatitis
vi. Gastric carcinoma
vii. Recurrent appendicitis
viii. Functional dyspepsia

14. Dysphagia

CAUSES

i. Acute tonsillitis
ii. Peritonsillar abscess
iii. Bulbar and pseudobulbar palsy
iv. Foreign body in esophagus
v. Peptic esophagitis
vi. Carcinoma esophagus
vii. Caustic stricture
viii. Achlasia
ix. Scleroderma
x. Diabetic neuropathy
xi. Plummer Vinson syndrome
xii. Globus hystericus

15. Haematemesis and Melaena

CAUSES

i. Esophageal varices
ii. Peptic ulcer
iii. Gastric carcinoma
iv. Gastric erosions

16. Vomiting

CAUSES

i. Gastritis
ii. Peptic ulcer
iii. Diabetic ketoacidosis
iv. Hypercalcemia
v. Addison disease
vi. Pyloric stenosis
vii. Intestinal Obstruction
viii. Psychogenic vomiting
ix. Drug induced e.g iron, Digoxin, KCl, opiates etc
x. Raised intracranial pressure
xi. Migraine

17. Generalized Swelling

CAUSES

i. Nephritic syndrome
ii. Cirrhosis liver
iii. CCF
iv. Angioedema
v. Myxedema

18. Weight Loss

CAUSES

i. TB
ii. Diabetic mellitus
iii. Hyperthyroidism
iv. Addison disease
v. Chronic hepatitis
vi. Cirrhosis liver
vii. CRF
viii. Carcinoma of stomach, colon, liver, pancreas and lung
ix. Lymphomas
x. Leukemias
xi. Anorexia nervosa, anxiety and depression
xii. Malabsorption
xiii. Helminthiasis

19. Fever

CAUSES

i. Malaria
ii. Typhoid
iii. Paratyphoid

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iv. TB
v. Brucellosis
vi. Pneumonia
vii. Pyelonephritis
viii. Lung abscess
ix. Empyema
x. Subphrenic abscess
xi. Influenza
xii. Measles
xiii. Mumps or Chicken pox
xiv. SLE
xv. Rheumatic fever
xvi. Rheumatoid arthritis
xvii. Lymphomas
xviii. Leukemias
xix. Hypernephroma
xx. Dermamyositis
xxi. Drug induced

20. Abdominal Distension (Ascites)

CAUSES

i. Cirrhosis, portal HTN
ii. CHF
iii. Chronic renal disease
iv. Massive fluid overload
v. Tuberculous peritonitis (exudates)
vi. Malignancy (exudates)
vii. Hypoalbuminemia
viii. Peripheral vasodilation secondary to endotoxin induced release of nitrous oxide, which leads to increased rennin secretion (and thus secondary hyperalsosteronism)
ix. Impaired liver inactivation of aldosterone
x. Constrictive pericarditis
xi. Budd chiari syndrome
xii. Nephrotic syndrome (transudate)

21. Cough and Expectoration

CAUSES

i. Pharyngitis
ii. Tonsillitis
iii. Sinusitis
iv. Tracheitis
v. Acute and chronic bronchitis

vi. Pneumonia
vii. Lung abscess
viii. Bronchiectasis
ix. Pulmonary TB
x. Bronchial asthma and chronic bronchitis
xi. Pulmonary fibrosis including pneumoconiosis
xii. Carcinoma bronchus
xiii. Carcinoma larynx
xiv. Pulmonary edema
xv. Recurrent laryngeal nerve palsy
xvi. ACE inhibitors
xvii. Interstitial lung disease

22. Palpitations

CAUSES

i. Atrial fibrillation
ii. Atrial flutter
iii. Paroxysmal atrial tachycardia
iv. Atrial premature beats
v. Ventricular premature beats
vi. Anxiety
vii. Exercise
viii. Thyroid disease

23. Pain Lumbar Region

CAUSES

i. UTI
ii. Tumours of kidneys
iii. Hydronephrosis
iv. Polycystic kidneys
v. Ureteric colic

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PMDC Step 3 Station Questions

(New Pattern Exam Conducted by PIMS)

8th September 2016 Morning Stations

1.Cardiopulmonary resuscitation of Infant
2. Back of Chest Examination / Thyriod Examination
3 Jaundice Examination Pre Hepatic, Hepatic and Post Hepatic Causes.
4. Jaundice Case with cross Question Biliary Obstruction.
5 Pterygium Pic and treatment
6 Tonsilitis Pic Enlarge Tonsil with White Patches and its causes and treatment.
7 Abdomen Examination
8 Histosalpangeogram pic of Fallopian Tube Block.
9. Eclampsia and tx
10.X ray of Barium Esophagus.
11 ECG of Inferior Wall MI and its Risk Factors.
12 Pic of Alopecia Areata and its associated disease.
13 Depression its tx.
14 Fever with Respiratory Distress IMCI classification

8th September 2016 Evening Station

1. GPE, viva on Jaundice
2. Examination of Abdomen and related question about Hepatosplenomegaly.
3. Obstructive Jaundice
4.Eclampsia Case
5.X ray Uterosalpingogram, Tubal blockage Management, in vitro Fertilization.
6. Pterygium Case
7. Examination of Anemic patient.Viva on Anemia
8.Patient of Hyperthyroidism. Related Question.
9.Tonsillitis, Types and Diagnostic differential
10.ECG. Risk factor of MI.
11. Pneumonia, Classification. Management.
12. Dummy, Cardiopulmonary arrest, CPR
13.Alopecia Areata
14.Major Depression Case (Counselling)
15.X ray Lateral view, Barium Study, Indication and Contraindication

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9th September 2016 Morning Stations

1)Visual acuity
2)Palpate abdomen + Viva
3)Examine Abdomen...Paraumbilical Hernia + Hernia Viva
4)Tinea Corporis Pic
5)Normal CXR...Normal Structures
6)Multinodular Goiter Examination + Viva Thyroid
7)Hyperthyroidism...Graves disease
8)Schizophrenia + Viva
9)Severe Dehydration Scenario + tx
10)Tb Scenario in 2 yr old Child + rx
11)Dummy … Cardiac arrest … What will you do ? + viva
12)IUCD. Copper T + viva
13)Tracheostomy Tube uses/size
14)CTG + Viva
15)Hypokalemia/Hyponatremia cx & rx

9th September 2016 Evening Stations

1.Tinea Corporis Spot dx
2.Copper T
3.Normal X-ray
4.TB case in child by CSF report
5. Abdomen Exam finding Hernia Incisional
6.CPR adult
7.Examination of Neck (Goiter)
8.Schizophrenia case
9.CTG
10.Abdomen Inspection Palpation Patient was with Foleys
11.Graves Disease Spot dx
12.Tracheostomy Tube
14.Snellen Chart with Visual Acuity
15. Severe Dehydration in Child Labs findings

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10th September 2016 Stations

1.Status Asthamaticus
2.Jaundice (EBF)
3.Butterfly rash (SLE)
4.Hernia Exam
5.Respiratory Exam
6.GPE (General Physical Examination)
7.Abdominal Inspection
8.ECT Machine Picture
9.Laparoscopy (Everything about it)
10.Shingles
11.CSOM
12.Wrigleys Outlet Forceps
13.PPH (Everything)
14.Chalazion
15.Orthopedics – X ray both hands (carpal bone names and radius ulna labelling) and X ray leg and foot (foot bones and tibia fibula)

PMDC NUMS Step 3 Station Questions

15th July 2017 Morning & Evening Stations

1. Oropharyngeal (Orolaryngeal tube) PIC/Types/Uses/Indications/Contraindications
2. Bell's Palsy PIC
   - A. Diagnosis
   - B. Which Nerve Involved?
   - C. Management
   - D. How facial nerve Palsy occur after Middle Ear Infection?
   - E. What is treatment of Ch CSOM with cholesteatoma?
3. Right eye Ptosis PIC:
   - A. Diagnosis?
   - B. Single Complication?
   - C. Symptoms?
   - D. Treatment
   - E. Two Surgical Procedures Names?
4. Anterior Dislocation of Shoulder Joint (X-Ray):
   - A. Findings on x ray?
   - B. Diagnosis?
   - C. Types of Dislocation?
   - D. Complications?
   - E. Management?
5. Breaking Bad News about adenocarcinoma of Colon
6. A. Case of Iron deficiency Anemia in Pregnancy (All lab reports show anemia), Causes & How to treat?

   B. 1 with PPH going to Shock, How will you Manage Stepwise? Whats lab investigations you want to check?
7. 1 mint Computer Simulations ECG of Ventricular Taquiarrhythmias/VT
   - A. Diagnosis?
   - B. How rate, rhythm, QRS complex and Rx
8. Paediatrics: Case of Organophosphate Poisoning
   - A. Diagnose?
   - B. Rx
9. Counselling about Obesity, How to decrease weight (If not decrease then what will happen)? (Professor was patient)
10. Computer Simulations:

    20 Seconds Video of Parkinson then asked 4 Questions:
    - A. Gait
    - B. What Other Symptoms Present in this disease?
    - C. Diagnose?
    - D. One Treatment Only?

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11. Anterior Chest Wall Full Exam (Respiratory Exam) then VIVA
    A. Causes of Stony dull Percussion?
    B. Causes of Fluid on X ray?
12. Liver Palpation (Hepatomegaly Causes)
13. 3 Cases Contraception & Justification one line
    A. 23 yr female with some hair on face rest normal
    B. 35 yr old female house wife with 5 children
    C. 40 yr old banker, multipara with fibroids
14. Pleural Effusion caused By TB (Low grade fever & Cough)
    A. X ray Findings?
    B. Diagnosis?
    C. How to Confirm (Investigations)?
    D. Management?
15. Complete History of Chest Pain in 2 Minutes
    Causes of Tracheal Shift VIVA

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PMDC NUMS Step 3 Station Questions

16th July 2017 Morning & Evening Stations

1. To Take History of SOB
2. ECG: SVT/A.Fibrillation/Atrial Flutter (rate, rhythm, dx and tx)
3. CVS: Examen the Precordium
4. Right Sided Facial Palsy (dx, features and nerve involved)
5. Counselling of Smoking
6. Paediatrics: Case Scenario of 8 Month Old (Severe Dehydration/Hypovolemic Shock) dx , markers of tissue Perfusion and Management
7. ENT: Radiography to identify Paranasal Sinuses and other Structures i.e Nasal Septum, Infra-orbital Foramen etc
8. Surgery: Complete Examination of Kidneys & Viva
9. Accident Victim Counselling of amputation right leg
10. Radiography of right leg of motorcycle accident victim having fractured tibia and fibula along with wounds (type of injury, classify compound fracture and management)
11. Instrument: Morris Retractor (Identify, Parts, Use and Viva)
12. Obstetrics: Management Steps of PPH in labor room
13. Eye: Ectropion (dx, complications and Rx)
14. Gynaecology: Fibroid Counselling
15. Diagnosis: Case of Respiratory acidosis/Asthma (dx, onset, type & management)

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PMDC NUMS Step 3 Station Questions

22 July 2017 Morning & Evening Stations

1. Eclampsia…MgSO4 & Hydralazine ki dose and mode
2. Hydtaiform Mole/ Molar Pregnancy … Rx and Follow Up
3. Entropion & Ectropion
4. ECG: SVT/Myocardial Infarction/Sinus Tachycardia
5. Precordium Examination
6. SOB History
7. Paediatrics: Foreign Body Aspiration/Bronchial Aspiration/Foreign Body in Child airways
8. X ray: Colles Fracture, Complete anatomy, Rx and Complication
9. Abdomen Examination: Spleen Palpation (Causes of Splenomegaly & Hepatomegaly)/Umbilical Hernia Examen & related Questions
10. Depression Counselling
11. Breaking Bad News to Father Whose Son has died
12. Laryngoscope
13. Acute Bacterial Tonsillitis & Diphtheria
14. Romberg Test, Nose to finger test (Manuver) & dysdiadokenesia..dx Cerebellar disease & Causes
15. Chronic Kidney Failure/Renal Failure: Hyperkalemia, ECG Findings, ECHO

PMDC NUMS Step 3 Station Questions

23rd July 2017 Morning & Evening Stations

1. A. Lung X Ray Findings: Bilateral Hilar Lymphadenopathy
   B. PIC Identify: Erythema Nodosum Lesions (Lower Limb Pic)
   C. Diagnosis: Sarcoidosis
   D. Further Investigations
2. Breaking a Bad News to patient that he has retained swab after Abdominal Surgery
3. To Take History of Chest Pain
4. Female with Irregular Menstrual Bleeding (Heavy Flow): Menorrhagia (Diagnosis, Causes of Menorrhage, Management)
5. Fasting Blood Sugar (118) of 20 Week Pregnant female … Gestational Diabetes all Related Questions Including dx (Diagnosis, What Complications can occur in Mother and Child during Pregnancy, What further Investigations can be performed)
6. Respiratory Examination (Inspection, Palpation, Percussion, Auscultation)
7. Counselling with a patient which has End Stage Kidney Disease/Renal Failure
8. 1 Year Old Child, 9 Kg Weight, diarrhea + Vomiting, Sunken Eyes, Skin Pinching is delayed….. A. WHO Classification of dehydration, Dx, Management …. Severe Dehydration Managment (All related Questions)
9. Two Way Foleys Catheter Insertion in Female and cx (Foley Catheter Pic, For female patient of Urinary Retention) A.Name B. Indications C. Procedure
10. Liver Palpation/Examination (Hepatomegaly Causes)
11. Pic Of Vocal Cords:
    A. Instrument to see this Structure: Laryngoscopy
    B. Diagnosis: Vocal Cord Nodule
    C. What further Procedure will you do: Biopsy
12. 3rd Degree Heart Block ECG: Rate, Rhythm, Diagnosis & Treatment
13. Bells Palsy Video..dx Signs and abnormalities & Causes (7th Nerve Palsy Simulation: A. Which Nerve is Involved? B. How Will you test this Nerve C. Name One Condition where it is affected D. What Signs are present in this Simulation?
14. RTA… X Ray of Pelvis…Hip Fracture (Symphesis of Pubis) Ileocecal Joint Dislocation…. Diagnosis, Name of Investigation, Complications, Management
15. PIC: Pterygium (Diagnosis, Causes of Vision Loss, Management)

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APPENDIX 3

SKILLS AND COMPETENCIES REQUIRED OF AN MBBS GRADUATE AND A HOUSE OFFICER BY THE END OF THE HOUSEJOB / INTERNSHIP / FOUNDATON YEAR

The Clinical Skills Examination (CSE) is designed to assess a candidate's competence at skills essential for a safe general physician.

Following are the competencies expected by graduating house officers and will be used to develop the Clinical Skills Examination (CSE) in conjunction with the theory syllabus above.

Clinical Skills list:

1. Obtaining an appropriate and relevant history and identifying the main findings
2. Performing systemic and mental state examination along with appropriate documentation
3. Establishing a differential diagnosis
4. Measurement of temperature, respiratory rate, pulse rate, blood pressure, oxygen saturations, NG output and urine output
5. Taking samples of venous blood to test for the growth of infectious organisms in proper culture bottles
6. Carrying out arterial blood gas and acid base sampling from the radial artery in adults
7. Perform essential lifesaving procedure (Basic Life Support, tracheostomy, endotracheal intubation and chest intubation)
8. Carrying out nasogastric tube placement
9. Measurement of central venous pressure (CVP)
10. Performing airway care including simple adjuncts (oro-pharyngeal airway or laryngeal masks, naso-tracheal airway)
11. Carrying out venepunctures
12. Measuring capillary blood glucose
13. Carrying out a urine multi-dipstick test
14. Carrying out a 3- and 12-lead electrocardiogram
15. Use the correct technique to apply sterile swabs to the nose, throat, skin and wounds
16. Requesting and interpreting the results of appropriate investigations to confirm clinical findings
17. Interpretation of X-rays of upper and lower limbs, chest, abdomen and pelvis
18. Setting up an infusion
19. Prescribing and administering oxygen
20. Preparing and administering injectable (intramuscular, subcutaneous, intravenous) drugs
21. Injecting or topically applying local anaesthetics
22. Carrying out intravenous cannulation
23. Carrying out safe and appropriate blood transfusion
24. Carrying out male and female urinary catheterization
25. Carrying out wound care and basic wound closure and dressing

26. Applying splint for fractures
27. Performing surgical scrubbing up
28. Performing digital rectal examination and Proctoscopy
29. Performing and interpreting peak flow using simple devises
30. Calculating BMI, carrying out nutritional assessment of patients and guiding them according to their caloric requirements
31. Performing basic ophthalmoscopy and identifying common abnormalities
32. Performing basic oto-scopy and identifying common abnormalities
33. Demonstrating that they are good communicators
34. Communicating with patients about the procedures
35. Demonstrating that they are sensitive (empathetic) and respond to the needs and expectations of patients irrespective of their caste, gender and economic status
36. Using the correct techniques for moving and handling patients, including those who are frail
37. Asking for patient's informed consent
38. Instructing patients in the use of devices for inhaled medication
39. Prescribing medicines safely and effectively and giving clear explanations to patients
40. Demonstrating an understanding of the safety procedures involved in prescribing controlled drugs
41. Demonstrating sound knowledge concerning confidentiality and anonymity
42. Introducing themselves to patients and colleagues with appropriate confidence and authority ensuring that patients and colleagues understand their role, remit and limitations
43. Demonstrating respect for patients' rights to refuse treatment or take part in teaching or research

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Imp Topics of Paediatrics for VIVA

1. Erb Palsy 2. Meningitis & Types 3. Prematurity 4. Pneumoperitoneum

5. Acute Glomerolonephritis 6. Ground Glass appearance on X-Ray 7. Oropharyngeal airway 8. Apgar Score 9. Bag & Mask Ventilation 10. Paracentesis 11. Lumbar Puncture Needle 12. Pleural Tap 13. Aortic Regurgitation 14. Aortic Stenosis 15. Mitral Stenosis 16. Mitral Regurgitation 17. Congenital Heart diseases (TOF, ASD, VSD, PDA, Coarctation of aorta) 18. Cephalhematoma 19. Diabetic Mother Child 20. Space device with Inhaler 21. Gower's Sign 22. Cyanotic Spells, Clubbing of fingers (TOF) 23. Developmental Milestone 24. Facial Nerve Palsy, Bell's Palsy 25. Hemarthrosis/ Hemophilia 26. ITP 27. HSP 28. Pulmonary TB 29. Acute Bacterial Tonsilitis 30. Pharyngeal Diphtheria 31. MUMPS 32. Measles 33. Vitamin A Deficiency 34. Myocarditis 35. Rubella 36. Tetanus Neonatorum 37. Lock Jaw 38. Rickets 39. Nephrotic Syndrome 40. UTI 41. Dehydration/Types 42. Complications of Bottle feeding 43. EPI 44. Primary & Secondary Malnutrition 45. Marasmus 46. Tinea Corporis/Ring Worm Infection 47. Miliary TB 48. Hepatomegaly Causes 49. Ascites Causes 50. Tuberculous Spine 51. TB Treatment 52. Side effects of TB Drugs 53. Dosage & Duration of TB Drugs 54. Mantoux Test 55. Congenital Hypothyroidism/Cretinism 56. Cervical Lymph adenitis 57. Impetigo 58. Infantile Seborrhoeic dermatitis 59. Thalasemia 60. Sickle Cell Anemia 61. Iron deficiency anemia 62. Hemolytic Anemia 63. Scabies 64. Down Syndrome 65. Facial Nerve Palsy 66. Kwashiorkor 67. Breastfeeding 68. Diarrhoea 69. Severe Dehydration 70. Foreign body in airway 71. Bitot Spots 72. Moderate Dehydration 73. Pneumonia 74. Acne Vulgaris 75. Asthma 76. Kernicterus 77. Physiological & Pathological Jaundice 78. Febrile Seizure 79. Epilepsy 80. Typhoid Fever 81. Kawasaki Disease 82. Pneumothorax 83. Chicken Pox 84. Polio 85. Dengue Fever 86. Malaria 87. SLE 88. Rheumatic Fever 89. Causes of Generalized Edema 90. Neural Tube defect 91. Acute renal failure 92. Steeple Sign (Croup) 93. Thumbprint sign (Epiglotitis) 94. Immunizations 95. Jaundice 96. Neonatal Sepsis 97. TORCH Infections 98. Abnormalities of Chromosomes 99. Bronchiolitis 100. Cystic Fibrosis 101. Atopic Dermatitis 102. Contact Dermatitis 103. Orbital Cellulitis 104. Otitis Media 105. Otitis Media with Effusion 106. Infective Endocarditis 107. HOCM 108. Pericarditis 109. HTN 110. EA & TEF 111. GERD 112. Duodenal Atresia 113. Meconium Ileus 114. Hirschprung Disease 115. Meckel Diverticulum 116. Intussusception 117. VUR 118. Polycystic Kidney Disease 118. Undescended Testes 119. Varicocele 120. Testicular Tumors 121. Hyperthyroidism 122. Diabetes Mellitus 123. Cushing Syndrome 124. Hyperthyroidism 125. Scoliosis 126. Osteomyelitis 127. Septic arthritis 128. Osteosarcoma 129. Ewing Sarcoma 130. Osteogenesis Imperfecta 131. Lead Poisoning 132. Worm Infestation 133. Megaloblastic Anemia 134. G6PD anemia 135. Hereditary Spherocytosis 136. Von Willibrand Disease 137. ALL 138. Hodgkin Lymphoma 139. Non Hodgkin Lymphoma 140. Wilms Tumor 141. Neuroblastoma 142. Pheochromocytoma 143. Rhandomyosarcoma 144. Hydrocephalus 145. Cerebral Palsy 146. Wilson Disease 147. Myasthenia Gravis 148. Muscular Dystrophies 149. Guillain Barre Syndrome 150. Pertussis 151. Tuberculous Meningitis 152. AIDS 153. Ascariasis

Imp Topics of Medicine for VIVA

1. Examination of Generalized Lymph Nodes, Causes of Lymphadenopathy 2. Types of Lymphoma, Clinical difference of Hodgkin Lymphoma & Non Hodgkin Lymphoma 3. TB 4. Examination of abdomen 5. ATT drugs, side effects, contraindications 6. Signs of Peritonitis 7. Examination of Chest 8. Asthma & Treatment of acute attack, Status Asthmatics 9. Anterior Wall Myocardial Infarction 10. Pleural Effusion & Causes & Investigations 11. Hydrocephalus 12. Hemoptysis causes 13. ETT Indications 14. Basal cell Carcinoma 15. Squamous cell carcinoma 16. Acne 17. Psoriasis 18. Murmurs Types 19. Inspection, Palpation, Percussion and Auscultation of Chest/Respiratory System 20. Splenomegaly Causes 21. Malaria 22. Polycystic Kidney Disease, Cardiac Complications, CNS Complications 23. Hyperthyroidism/Hypothyroidism 24. Sarcoidosis & its Dermatological Manifestations 25. Pneumonia & X Ray finding (Consolidation) 26. ECG of Myocardial Infarction 27. X ray finding of Pulmonary TB & ATT drugs duration, Side effects 28. Motor Examination of Lower Limbs 29. Management of acute Liver failure 30. Trigeminal Neuralgia, Diagnosis, Complications, Management 31. Hypoglycemia 32. Diabetes Mellitus 33. DKA 34. Typhoid Fever 35. UTI 36. Hepatitis A, B, C, D , E 37. Liver Cirrhosis 38. Physical Examination of Neck 39. Types of Tremors & type of tremor in Hyperthyroidism 40. Complete thyroid Examination 41. Cardiomegaly causes 42. Gas Under diaphragm 43. Gastritis 44. Peptic Ulcer Disease/Complications 45. Scabies 46. Shingles 47. Epilepsy 48. Hepatomegaly causes 49. Splenomegaly causes 50. Tests for Hepatitis B & C, Treatment 51. SLE 52. Enzymes raised in MI 53. 2nd Degree Heart Block & 3rd degree Heart Block 54. Left Bundle branch Block 55. Tinea Capitis & Herpes Labialis 56. Jaundice 57. Hepatocellular Carcinoma & Liver Cirrhosis 58. Electrolyte disturbances 59. Metabolic Acidosis 60. Respiratory Acidosis 61. X ray: Air Under Diaphragma 62. WPW Syndrome 63. Ramsay Hunt Syndrome 64. Ascites 65. Examination of Pericardium 66. Asthma 67. ECG: Anterior Wall MI 68. Chicken Pox 69. Diabetes & HTN 70. ETT tube 71. Meningitis 72. Encephalitis 73. Brain Abscess 74. Thyroid Examination 75. 3rd Nerve Examination 76. Mitral Stenosis 77. Pneumonia X Ray 78. Acute Renal Failure 79. Chronic Renal Failure 80. Iron deficiency anemia 81. Diabetic Ketoacidosis 82. Myasthenia Gravis 83. Malar Rash/Butter fly Rash (SLE) 84. Cerebral Infarction 85. Acute MI & Treatment 86. Lumbar Puncture Needle 87. Acanthosis Nigricans 88. Respiratory Alkalosis 89. Metabolic Alkalosis 90. Metabolic Acidosis 91. Infective Endocarditis 92. Guillian Barre Syndrome 93. Bilateral Ptosis 94. Cerebral Haemorrhage 95. Complete Ptosis of right eye 96. Scurvy 97. X ray KUB (Stones) 98. Graves Disease 99. Causes of Clubbing 100. Rheumatic Heart Disease 101. Asthma/COPD 102. Emphysema 103. Abducen Nerve Palsy 104. Chronic Liver Disease 105. X ray (Right Upper Lobe Consolidation) 106. Ramsay Hunt Syndrome 107. Mitral Stenosis 108. Aortic Stenosis 109. Foley Catheter Uses 110. Nasogastric Tube 111. Bronchogenic Carcinoma 112. Glomerulonephritis 113. Paroxysmal Ventricular Tachycardia 114. SLE 115. Lactic ACIDOSIS 116. Herpes Zoster 117. Pneumonia 118. TB 119. Nephrotic Syndrome 120. Psoriasis 121. Atrial Fibrillation 122. Rheumatoid Arthritis 123. Left Ventricular Hypertrophy: ECG findings 124. Pyopneumothorax/ Hydropneumothorax 125. Bone Marrow Biopsy Needle /Indications 126. DM Complications, Macrovascular Complications/ Microvascular Complications 127. Parkinson Disease 128. Respiratory Examination/Liver Examination 129. Pleural Effusion causes 130. ECG: SVT/3rd degree Block/ MI 131. CVS: Examen the Precordium 132. Cerebellar Disease/Examen/Manuver 133. CKD 134. Hyperkalemia/Hypokalemia 135. Sarcoidosis/X ray findings/ Erythema Nodosum 136. Thyrotoxicosis 137. Cushing Disease 138. Side effects of Steroids 139. DMARD 140. Scleroderma 141. Ankylosing Spondylitis 142. Osteoarthritis 143. Gout 144. Septic Arthritis 145. Crohn Disease 146. Ulcerative Colitis 147. Primary Biliary Cirrhosis 148. Angina 149. MI 150. HTN 151. CHF 152. Pulmonary Edema 153. Mitral Valve Prolapse 154. HOCM 155. CLL 156. CML 157. Hodgkin & Non Hodgkin Lymphoma 158. ITP 159. Lung ABSCESS

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Imp Topics of Gynaecology & Obstetrics for VIVA

1. Uterine Prolapse 2. Hysterectomy 3. Manchester Repair 4. Obstetrics Examination 5. USG Obtetrics 6. PPH 7. Abdominal Hysterectomy 8. Ectopic Pregnancy 9. Ovarian Carcinoma 10. Placenta Previa 11. Eclampsia 12. PreEclampsia 13. Gestational Diabetes 14. Iron deficiency anemia in pregnant woman 15. Copper IUD, Indications, Complications, Contraindications 16. Types of Presentation, Fetal Complications 17. Management of Ectopic Pregnancy 18. Magnesium Sulphate Indication, side effect and how to manage its Toxicity 19. 5 Causes of PV Bleeding in 3rd Trimester 20. Amniocentesis, Name 2 diseases in which it is useful 21. Contraception/Types/Indications/Contraindications/Side effects/Complications 22. Vaginal Discharge History 23. Bacterial Vaginosis 24. Syphilis 25. AIDS 26. Obstetric Cholestasis effect on mother & Child 27. Major Causes of Maternal Death in Pakistan 28. Definition of Maternal Mortality 29. Cancer Cervix 30. Breast Cancer 31. Abortion/Types/Incomplete abortion 32. OCPS 33. History of Menorrhagia 34. Menstrual History 35. Still Birth Definition 36. Prenatal Death & Cause 37. Torsion of Ovary/Ruptured Ovarian Cyst (dx and management) 38. PIC of transverse lie & arm presentation of pregnancy, Complications 39. Vaginal Prolapse 2nd Degree 40. Diagnostic case of Ectopic Pregnancy 41. CTG 42. Partogram 43. Preterm 44. Post term 45. Diabetic Mother baby 46. Diagnosis, Causes & Management of Menorrhagia 47. Diagnosis, Investigations & Complications in Gestational Diabetes 48. MgSO4 in Eclampsia 49. Hydatiform Mole 50. Molar Pregnancy 51. Management Steps of PPH in labor Room 52. Fibroid Counselling 53. Questions about Contraceptions & their justification 54. Twin Transfusion Syndrome 55. Dilatation & Curettage Indications/Complications 56. Fibroid Uterus 57. Oral Contraceptive Pills/Absolute Contraindications/ Relative Contraindications 58. Spina Bifida 59. Forceps delivery/Indications 60. Cervical Polyp 61. Uterovaginal Prolapsed 62. Amniocentesis 63. Norplant/Levonorgestril (Advantages & Disadvantages) 64. Cardiotocography (CTG) 65. Implanon 66. IUGR 67. Twin Pregnancy 68. CRL Measurement of fetus 69. Iron deficiency Anemia Investigations/Treatment 70. Causes of PPH/Management 71. Puerperal Blues/Psychosis 72. Puerperal Depression 73. Mastitis of Breast 74. Benefits of Breastfeeding 75. Cuso/bivalve Speculum 76. Hysterosalpingogram 77. Copper T (An IUD)/Mode of action/Contraindication 78. 5 Indications for induction of labour 79. PCO 80. Rh disease 81. Biophysical Profile 82. Preterm Labour 83. Ovarian Carcinoma 84. Hegars Dilators 85. SIM'S Vaginal Speculum 86. Metal Urinary Catheter 86. Hodge Pessary (Indications & Contraindications 87. Ring Forceps 88. Sponge Forceps 89. Ovum Forceps 90. IUG 91. Combination Contraceptives (Estrogen & Progestin) 92. Post term Labour 93. Contraception v.v.imp 94. Eclampsia & Preaclampsia v.v imp 95. Folic acid/Megaloblastic deficiency in Pregnant woman 96. CTG v.v imp 97. Episiotomy Scissor

Secrets of OSPE/OSCE BY DR. NAEEM AKHTAR JOYIA 7th Edition

Imp Topics of EYE for VIVA

1. Causes of Corneal Ulcer 2. Pathology of Glaucoma/Types/Managment 3. Proptosis Causes 4. Contraindicated drug for Corneal Ulcer 5. To Check Visual Field 6. Cataract 7. Define Glaucoma. Signs of Glaucoma, Treatment 8. Examen Visual field 8. Dacrocystitis 9. Stye, Diagnosis, Management 10. Visual field Examination 11. Esotropia 12. Corneal reflex test 13. Do Perimetry & What are the causes of bitemporal anopia 14. Stye, its management & its causes 15. Red Eye Causes 16. Pupillary Reflex, Visual field 17. 3rd Nerve Examination 18. Ptergium 19. Visual field defect 20. Squint (dx & Management) 21. Exopthalmos (Graves disease) 22. Ptosis 23. Ectropion (dx, complications, Rx) 24. Entropion & Ectropion 25. Pterygium (Diagnosis, Management) 26. Causes of red eye 27. Cataract 28. Glaucoma 29. Retinoblastoma 30. Diabetic retinopathy 31. Hypertensive retinopathy 32. Conjunctivitis/Types 33. Myopia 34. Presbyopia 34. Squint 35. Eye Muscles 36. Oculomotor nerve/Abducen Nerve/Trochlear Nerve 37. KF rings 38. Stye (Hordeolum) 39. Chalazion (Tarsal or Meibomian) 40. Papilledema 41. Exophthalmos 42. Leucocoria (White reflex)/Retinoblastoma 43. Bilateral Ptosis 44. Optic atrophy 45. 3rd Nerve Palsy 46. Acute-dacryo-adenitis 47. Mature cataract 48. Acute mucopurulent Conjunctivitis 49. Bitot spots 50. Stages of Hypertensive retinopathy 51. Instruments all

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Imp Topics of ENT for VIVA

1. Epistaxis (dx, management, counseling) 2. Steeple Sign (Croup) Etiology, Laryngomalacia Rx 3. Oral Cavity Examination 4. Laryngeal Nodule 5. Examine Oropharyngeal Cavity, Nasal Speculum, Laryngoscope, Anatomy of tongue & Pharynx 6. Otitis media & complications 7. Acute Tonsilitis 8. Cancer larynx 9. Nasal Obstruction & Epistaxis 10. Tonsillectomy/Indications/ Contraindications/Complications 11. Trachestomy/Indications/Contraindications/Complications 12. Examen Oral cavity 13. Nasal Speculum 14. Types of Tonsillitis 15. Identify different instruments 16. Audiogram 17. Weber test 18. Rinne test 19. Difference b/w Conductive & Sensoneural loss 20. Esophageal Cancer 21. Bilateral Nasal Septal hematoma 22. Septal Abscess after trauma 23. Perform Rinne test on patient? What is normal rinne test? What is Weber test? 24. What is Presbycusis 25. Meniere Disease 26. Vertigo 27. Ototoxic drugs 28. Tuning fork parts/uses of tunning fork 29. Nasal Speculum 30. Treatment of DNS? Difference b/w SMR & Septoplasty? Complications of Septoplasty 31. Carcinoma of Lip 32. Examen Oral Cavity 33. Indications of Tonsillectomy/Complications of Tonsillectomy 34. Esophageal Stricture 35. Causes of hoarseness of voice 36. TNM Stages of Cancer Larynx 37. Types of CSOM 38. Why children have frequently Otitis Media? 39. Tympanic membrane rupture 40. Oropahryngeal airway pic & related Questions 41. Idenitification of Paranasal Sinuses on X ray 42. Laryngoscope 43. Vocal Cord Nodule 44. Instruments all 45. X rays all

Imp Topics of Psychiatry & B.Sciences for VIVA

1. Depression 2. Schizophrenia 3. Bipolar disorder 4. Breaking Bad News to relatives of dead person 5. Generalized anxiety 6. Epilepsy 7. Depression (Classification of drugs for this disease) 8. OCD/Management 9. Depression treatment (Side effects of drugs used in depression) 10. Accept gift from patient or not? 11. Major depression/treatment 12. Schizophrenia/Main risk factor in this patient 13. PTSD 14. Panic disorder 15. Schizophrenia/ Diagnosis 16. Mania Counselling 17. PTSD Counselling 18. Depression (dx & Rx) 19. Breaking bad news to patient that he has retained swab after abdominal surgery 20. Breaking Bad news to father whose son has died 21. Accident Victim, Counselling of amputation of right leg 22. Breaking bad news, Cancer Colon 23. Neuroleptic Malignant Syndrome 24. Dementia 25. Suicidal risk factors 26. Counseling of diseases 27. Breaking Bad news v.v. imp

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Guidance related with VIVA

1. Believe in yourself and believe in ALLAH
2. Stay Cool, calm and confident.
3. Don't play with your expressions; keep a gentle smile on your face.
4. Take permission before entering the room (May I come in Sir?)
5. Your Voice must be strong, clear and audible.
6. If the Examiner shakes hand with you then it's ok; otherwise just say " Assalam o Alaikum Sir"!
7. Don't shake hand very firmly/hardly; be well mannered in hand shake.
8. Don't sit on the chair unless he/she tells you to sit.
9. Don't stare at the roof and walls, keep focus on the examiner.
10. Sit with your legs straight, don't sit with cross legs.
11. Your back must be straight, be alert and don't sit in a relaxed manner.
12. Don't sit with both hands holding each other. Keep them apart.
13. You will be asked to introduce yourself, prepare your introduction well.
14. Introduction is the most important part of any examiner because it's your first impression on the examiner. Avoid unnecessary details, stick to yourself only. Don't mention your family members, it will length the intro and examiner get bored. To-the-point introduction consists of 2 parts:
    i) Personal info: Your full name, father's name and your city along with district.
    ii) Education info: includes info about your degrees. Order must be latest degree first then move to the next recent one (MD/MBBS>>FSC>>Matric). Include the year of completion, your institution name, obtained GP, Percentage, Grade.
15. Answer in the same language in which the question is asked.
16. If you are not sure about any answer, say "Sorry Sir!" avoid guessing.
17. Look into the eyes of Examiner while answer to show your confidence.
18. Don't shake your head or move your hands while explaining.
19. Don't laugh if he tries to crack a joke. Just smile
20. Don't play with your dress, tie or shirt.
21. First think and then answer. Don't give the answer instantly because that will be considered a guess. Take your time even if you know the answer.
22. If you don't know the answer, still take your time and say sorry. Don't say sorry instantly.

PMDC NUMS Step 3 Station Questions

30 June 2018 Morning & Evening Stations

1. **Orthopedic Question: X-Ray of fracture of radius bone.**
    i. **What is your finding in x ray? Ans: fracture of shaft of radius**
    ii. **How will you manage? Ans: ATLS, ABCD, pain management, reduction and POP with elevated position (to avoid any clot formation and reaching to brain or lungs)**
    iii. **What is definite management? Fixation with screws and plates**
2. **Pregnant lady of 22 yrs of 36 weeks presents with fits and BP of 180/110?**
    i. **Diagnosis?**
    ii. **Management?**
    iii. **MgSO4 dose? All Questions solved Previously in Book**
3. **Lady of 45 yrs having massive bleeding since 2 yrs. Take History from patient. (Solved in Book)**
4. **Surgery: Patient has inguino scrotal hernia repaired with mesh surgery. (Detail about General anesthesia, about operation, Immediate & late complications, Not operated then complications) Counselling given in Book**
5. **i. Paeds I: Saima presents with his 8 yr old baby presents with severe loose stools since last night. Take History in details**
    ii. Paeds II: Video of boy with generalized Tonic Clonic Seizures? Identify findings in video, diagnosis……Epilepsy, Management of Epilepsy in Children?
6. **Surgery Instrument: 2 way foley catheter.**
    i. **Identify object?**
    ii. **3 indications?**
    iii. **3 complications?**
    (Solved in Book)
7. **EYE: 14 day boy presented by her mother with green colour diacharge & reddish eye.**
    i. **Diagnosis: Conjuntivitis (Suppurative Neonaturum)**
    ii. **Management**
    iii. **Complications (Solved previously)**
8. **ENT: Pic of Acute Tonsillitis with bilateral abscess**
    i. **Diagnosis?**
    ii. **Management?**
    iii. **Complications?**
    (Solved Previously)
9. **Medicine I: Chest X ray of LVF?**
    i. **Identify?**
    ii. **Findings?**
    iii. **Diagnosis?**
    iv. **Management?**

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10. Medicine II: Sound of Murmur on laptop with headphone?
    i. Diagnosis?
    ii. 3 Treatment
11. Interactive with Profesor:
    i. Patient with history of cough since long?
    ii. Take complete history
    iii. What is your diagnosis?
    iv. D/D and management?
12. Interactive with Profesor:
    i. Complete Chest & CVS Examination (Given in facebook group Secrets of OSPE/OSCE)
13. Interactive with Profesor:
    i. Complete physical examination of Abdomen & Kidney (Given in facebook group Secrets of OSPE/OSCE)
14. About Counselling:
    60 year old diabetic since long time presents with SOB, anemia, hyperkalemia metabolic acidosis, kidney of small size… Haemodialysis. Consent for haemodialysis from her daughter Saima and explain about haemodialysis, how its done, what r advantages, precautions.
15. ECG of Myocardial Infarction (Given in Book)

PMDC NUMS Step 3 Station Questions

1st JULY 2018 Morning & Evening Stations

1. STATION EYE: Trachoma
    i. Pic and Scenario
    ii. Diagnosis
    iii. WHO Classification
    iv. Treatment
    (Solved in Book)
2. Stations ENT: Coin like foreign body on X-Ray
    i. Diagnosis
    ii. Treatment
    iii. Complications if left untreated
    (Solved in Book)
3. Station 3: Diagnostic case of diabetic with labs:
    i. Academia/ Alkalemia
    ii. Calculate anion gap
    iii. Diagnosis
4. Station 4 Medicine: Chest Examination. Front & Back (Videos given in Secrets of OSPE/OSCE face book Group)
5. Station 5: Medicine
    Video of hand of benediction
    i. Write nerve lesion?
    ii. Further Investigations?
    iii. Diagnosis
6. Station Medicine: CVS
    History was Palpitations
    Give 3 differentials of this patient
7. Station ECG: Inf lateral wall MI
    i. PIC of ECG
    ii. Diagnosis
    iii. Management
    iv. Further Investigations
    v. Write abnormalities (rate, rhythm axis etc)
    Solved in Book
8. Station Surgery: Abdomen Examination Specially Spleen
    On inspection, scar mark for post appendectomy. Features of a scar. Perform cough reflex
9. Station 9 Surgery: 60 yr old Diabetic, Counselling about Ulcer on his right foot.

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10. Stations 10 Surgery:
    i. Breaking bad news to Son (his father died of acute MI)
    ii. Management of appendicular mass
11. Station 11 Orthopedic:
    i. Pic and case scenario of right tibial shaft fracture
    ii. Diagnosis?
    iii. Initial management?
    iv. Definite management?
    (Solved in Book)
12. Station 12 Obs Viva:
    i. PPH prevention.
    ii. Which stage of labour has highest risk of PPH and what is the most imp preventive step we do at 3rd stage?
13. Station 13 Gynaecology Viva:
    i. Instrument: Bivalved cuscos Speculum
    ii. Identify.
    iii. How you use it?
    iv. What are advantages?
    (Solved in Book)
14. Station 14 Paeds: History from mother of diarrhea and fever.
15. Station 15: Surgery Instrument
    i. Identify: Proctoscope
    ii. Indications
    iii. Complications
    iv. Name parts of Instrument
    (Solved in Book)

PMDC NUMS Step 3 Station Questions

7th JULY 2018 Morning & Evening Stations

1. Station Gynaecology:
    i. 24 yr old young girl, her first yr of marriage suitable contraceptive. Ans: Oral contraceptive
    ii. 42 yr old woman P6A1, suitable contraceptive: Ans IUCD (Copper T)
2. Station ENT:
    i. 2 types of deafness
    ii. 5 causes of conductive deafness
3. Station ECG:
    i. Clinical case CKD (creatinine 10, K+ 7.8)
    ii. ECG Findings: Tall T Waves, rate 100
    iii. Diagnostic: Hyperkalemia
    iv. Treatment: Insulin & Dextrose
4. Station Medicine: to take history
    i. Pt 68 yr old smoker with h/o blood with sputum & anorexia. To take history & tell diagnostic & differential (Pulmonary TB or Cancer of Lung)
5. Station Medicine: Clinical Simulation video diabetic pt, BP 190/110 mmHg, lower limb weakness.
    i. Positive findings: left lower limb & left upper limb weakness
    ii. Which is decreased: Power decreased
    iii. Diagnostic: Stroke pt with left sided hemiplejia
    iv. Investigation: CT Scan of Brain
6. CVS Examination (Video Given in Official facebook group Secrets of OSPE/OSCE)
7. Abdomen Examination (Video given in official facebook group)
8. Surgical Instrument Name & 3 Indications: Kosher Forcep
9. Dispensar pricked his finger while injecting Hepatitis B positive pt. Counselling & vaccination. Everything about Hepatitis B & HIV.
10. Take History of bleeding per rectum.
11. Station Orthopedic: X ray of fracture of shaft of Humerus.
    i. Diagnosis
    ii. Emergency treatment
    iii. Write 5 complications.
    iv. Definite treatment
    (Solved in Book)
12. Episiotomy related Question: Obs
    i. Stitch type
    ii. How to stitch?
    iii. Name of Layers?

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13. **Station Paeds: To take History from a mother for a Neonate of 10 day with 2 day history of fever.**
14. **Station EYE: Eye Instrument**
15. **Station Medicine:**
    - i. **Video & audio sound hear at mitral valve**
    - ii. **Murmur type**
    - iii. **Diagnostic**
    - iv. **Treatment**

PMDC NUMS Step 3 Station Questions

8th JULY 2018 Morning & Evening Stations

1. **Station Paeds: Fever & Fitz History**
2. **Station EYE: Cataract**
3. **Station Medicine: Facial Nerve Palsy**
4. **Station X ray Medicine: Pleural Effusion (TB)**
5. **Station Medicine: Respiratory Exam (Front of Chest) Given in Official facebook group Secrets of OSPE/OSCE … Secrets of UHS**
6. **Station Medicine: 3rd Nerve Palsy**
7. **Station Medicine: Chest Pain History**
8. **Station ECG: Heart Block Video**
9. **Station Surgery: Abdomen Exam (Video given in official facebook Group Secrets of OSPE/OSCE …Secrets of UHS)**
10. **Counselling: Celiac disease**
11. **Surgery Instrument: Sponge Holding Forcep**
12. **Station Surgery: Conscent for Cholecystectomy**
13. **Station Obs: Puerpura (Clinical Exam & History)**
14. **Pap Smear Procedure**
15. **Station Orthopedic: Femur Fracture**

(All Papers Solved In Book Secrets of OSPE/OSCE)

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PMDC NUMS Step 3 Station Questions

26th JANUARY 2019 Morning & Evening Stations

1. Station 1, Derma: Melanoma (Colour, Surface, Symmetry and Borderline) Diagnose and Treatment.
2. Station Breaking Bad News: patient came with MI, died due to cardiac arrest in Hospital. Give News to his brother and answer his Questions.
3. Station Medicine: CVS Exam in patient with H/O SOB & Orthopnea and Suspecting MI.
4. Station X ray Medicine Neuro: Facial Nerve Palsy, Exam 7th Nerve in patient , common cause and treatment.
5. Station Medicine: Diagnose, X ray of Chest (Pulmonary TB) Tell view, Findings, Diagnose and Treatment.
6. Station Paeds: You r H.O in Postnatal ward. How will you examine the patient.
7. Station Eye/ENT: (Nasolacrimal sac cyst) CT Scan of base of Skull. Identify technique , diagnose and what other tests you will perform to diagnose.
8. Station Surgery: Nodular Goiter/Warm, PIC of Goiter and PIC of Radioactive Iodine Scan, diagnose, technique, fluid used, what other tests you perform and what test for nature of disease.
9. Station Surgery: Acute Appendicitis (patient with history of 7 days of pain in RIF, take history focus on complaint and tell tests you perform.
10. Counselling: Consent from relative about taking of ventilator in a patient who died due Cerebral Infarction (Increased HTN)
11. Surgery Instrument: Neck Collar, a boy accident from bike and taken to hospital with this. Name the item (Cervical Collar) and tell when it is used.
12. Station Paeds/OBS: baby with history of loose motion (Acute Diarrohea) , diagnose and IMNCI Classification of Dehydration.
13. Station Medicine: Pneumonia/TB, take H/O cough, diagnose and causative agent.
14. Station Gynaecology: patient of 45 yrs with 2 yrs heavy menstrual bleeding. Take history of bleeding.
15. Station Orthopedic: Dislocation of Hip Joint & Sacroiliac Joint. X ray of hip Joint in a patient of 80 yrs, define anomaly in X ray and diagnose, Initial management, complications and definite treatment.

(All Papers Solved In Book Secrets of OSPE/OSCE)

PMDC NUMS Step 3 Station Questions

27th JANUARY 2019 Morning & Evening Stations

1. Station Paeds: 4 day baby Jaundice and Rh Incompatibility
2. Station EYE: Entropion management and complications
3. Station Medicine: H/O Chest Pain (Angina)
4. Station Medicine: CT Brain, (Epi or Extra dural Hematoma)
5. Station Medicine: Respiratory Exam (Back of Chest) Given in Official facebook group Secrets of OSPE/OSCE ... Secrets of UHS
6. Station Medicine: Sensory Examination below Knee
7. Station ENT : Labelling of Larynx
8. Station : Counselling, Breaking bad news of a mother who had CA Ovary
9. Station Surgery: Examination of Abdomen History (RIF Pain)
10. Counselling: Counselling of Type 1 DM for Insulin
11. Surgery Instrument: NG Tube (Identification, uses and Contraindications)
12. Station Derma: Basal Cell Carcinoma, Identification & treatment
13. Station Obs: Eclampsia treatment and dosage
14. Station: Contraception for 3-4 yrs (norplants) and multigravida pt (IUCD)
15. Station Orthopedic: Neck of Femur Fracture (Identification and Treatment)

(All Papers Solved In Book Secrets of OSPE/OSCE)

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Patient comes to you with a gift after treatment

Dr. should Refuse

اسلام وعلیکم۔

- دیکھیں پیشہ ورانہ تقاضوں کو مدنظر رکھتے ہوئے میں یہ تحفہ قبول نہیں کر سکتا۔
- میں آپ کی خدمات کی قدر کرتا ہوں۔
- اگر اس کے بعد بھی آپ کو کبھی کسی بھی طرح کی علاج کی ضرورت ہوئی تو میں حاضر ہوں۔
- میں یہ آپ کو یقین دہانی کرواتا ہوں کہ اس کے باوجود ہمارے درمیان ڈاکٹر مریض کے تعلق میں کوئی فرق نہیں آئے گا اور آپ کا علاج اسی دل جمی اور اسی طریقے سے جائے گا۔ جس طریقے سے پہلے کیا گیا۔
- میں اُمید کرتا ہوں آپ میری بات سمجھ رہے ہیں۔

اللہ حافظ

COUNSELLING

AL-ZHEIMER.S

AFTER INTRODUCTION

- کبھی نہ کبھی ہم سب بھول جاتے ہیں۔ عمر کے بڑھنے کے ساتھ یہ عمل متاثر ہو جاتا ہے۔
- مریض کی حقیقی وجہ معلوم نہیں۔ لیکن خون کی سپلائی کی کمی کے باعث یہ دماغ کے اس حصہ کی متاثر کرتی ہے۔ جس کا تعلق حالیہ واقعات کے یاد رکھنے سے ہوتا ہے۔
- مریض اپنی تکلیف میں دبکا رہتا ہے۔ شخصیت میں تبدیلی، چڑچڑا پن، بات ماننے سے انکار، اردگرد کے حالات سے بے خبر رہنا باتیں، چیزیں یاد رکھنے اور پہچاننے میں مشکل ان سب کو متاثر کرتی ہے۔
- جو چیزیں مددگار ثابت ہو سکتی ہیں وہ نام بار بار دہرائیں۔ ڈائری کا استعمال، حقائق کی یاددہانی Vitamin-E اور Ginko کا استعمال طبیعت زیادہ خراب ہو تو ڈاکٹر کے پاس آئیں کچھ Test کروانے کے بعد آپ Neurologist کے پاس جانے کا مشورہ دیا جا سکے۔

تعاون کا شکریہ

LEUKEMIA

After Introduction

- مجھے آپ کے بیٹے کی بیماری کے بارے میں بات چیت کرنی ہے۔
- جیسا کہ آپ اپنے بیٹے کو وزن اور خون میں کمی، جسم میں درد، infection کے بار بار ہونے یا نہ ٹھیک ہونے کے باعث تشریف لائے تھے۔
- ہم نے کچھ ٹیسٹ کروائے ہیں جس سے پتا چلا کہ آپکے بیٹے کو acute leukemia ہے۔ یہ ایسا مرض ہے۔ جس میں ہڈیوں کا گودا Abnormal سفید خلیے بنانا شروع کر دیتا ہے۔ جس سے خون کے صاف خلیے کام کرنا چھوڑ دیتے ہیں۔ مجھے افسوس کے ساتھ کہنا پڑ رہا ہے۔ کہ یہ کینسر کی ایک قسم ہے۔ اس کے لئے ہمیں ایک Test کروانا ہے۔ جس کو Bone Marrow Biopsy کہتے ہیں۔ تا کہ ہم اسکا علاج شروع کر سکیں۔
- اس مرض کا علاج شعاؤں کا ور ادویات کی مدد سے کیا جاتا ہے۔ bone M. transplant (گودا تبدیل کرنا ہے) بھی علاج میں شامل ہے۔
- ادویات کے کچھ side effect بھی ہیں جس میں بالوں کا گرنا۔ الٹی (vomiting)، Bleeding وغیرہ شامل ہیں، ہم سب۔ آپکی روزمرہ بنیاد پر بتاتے رہیں گے۔ مزید کچھ پوچھنا چاہیں تو پوچھ سکتے ہیں۔

CROHN'S DISEASE:

AFTER INTRODUCTION

- جیسا کہ آپ ہمارے پاس ڈائریا، بخار، پیٹ درد، فضلہ میں خون آنا، غذائیت کی کمی اور وزن میں کمی کے باعث تشریف لائے تھے۔
- آپ کے کچھ ٹیسٹ کروائے تھے۔ جس میں خون کا ٹیسٹ، پاخانہ ٹیسٹ اور Endoscopy شامل تھے جس سے ہمیں پتہ چلا کہ آپ کو آنتوں کی سوزش ہے۔
- یہ بیماری نظام ہضم کے مختلف حصوں کو متاثر کرتی ہے۔
- اسکی اصل وجہ معلوم نہیں ہے۔ لیکن یہ موروثی عوامل۔ فیملی history اور سگریٹ نوشی کی وجہ سے ہو سکتی ہے۔
- اسکا کوئی علاج موجود نہیں ہے۔ لیکن سوزش اور باقی علامات کو کم کرنے کے لئے مختلف ادویات کا استعمال کر سکتے ہیں جس میں Corticosteriod ، Antidiarrheal ، antibiotic اور pain killer شامل ہیں، اور ضرورت کے مطابق سرجری کا استعمال بھی کیا جا سکتا ہے۔

تعاون کا شکریہ۔

OBESITY

AFTER INTRODUCTION

- پروفیسر صاحب نے مجھے آپکے مسئلے کے بارے میں بات چیت کرنے کو کہا ہے۔
- آپ کو بتاتا چلوں کہ جسم میں چربی کی ذخیرہ پن ضرورت سے زیادہ چربی ہونے کو موٹاپا کہتے ہیں۔ یہ عمر کے تمام لوگوں میں ہوتا ہے۔ مگر درمیانی عمر کے لوگ اتنا زیادہ شکار ہوتے ہیں۔
- موٹاپے کا سب سے بڑا سبب زیادہ کھانا یا غلط اقسام کی غذا کھانا ہے۔ بہت سے cases میں موروثی بھی ہوسکتا ہے۔
- جذباتی انتشار اور ہارمون (Hormone) میں خرابی بھی اسکا سبب بن سکتی ہے۔
- موٹاپے کی وجہ سے آپ اور بھی مختلف بیماریوں جیسا کہ ذیابطیس (Diabetes) ہارٹ اٹیک ہائی کولیسٹرو اور ہائی بلیڈ پریشر میں مبتلا ہوسکتے ہیں۔
- اگر BMI 30 سے زیادہ ہے۔ تو ہم کہ سکتے ہیں۔ آپکو موٹاپا ہے۔
- موٹاپا کم کرنے کے لئے مختلف تھراپیز اور طریقہ کار موجوہ ہیں۔
- کھانے میں کمی، متوازن غذا اور سلاد کا استعمال، پانی کا زیادہ استعمال، تلی ہوئی اور روغن اشیاء سے پرہیز اور روزانہ 45 منٹ کی ورزش وزن کم کرنے میں موثر ثابت ہوتی ہے۔ مجھے اُمید ہے۔ کہ آپ ان سب باتوں کو عمل کرنے کی کوشش کریں گے۔

تعاون کا شکریہ۔

Thalasemia

AFTER INTRODUCTION

- جیسا کہ آپ اپنے بچے کو جلد کا پیلا ہونے۔ سانس پھولنے، وزن میں کمی ہڈیوں کی ساخت میں تبدیلی کی وجہ سے ہسپتال تشریف لائے تھے۔ آپ نے اپنے بچے کے کچھ test کروائے ہیں۔ جس میں ایک HB Electrophoresis شامل تھا جس سے ہمیں پتہ چلا کہ آپ کے بچے کو خون کی ایک مہلک بیماری ہے۔ جسے Thalasemia کہتے ہیں۔
- یہ ایک موروثی بیماری ہے جو والدین سے منتقل ہوتی ہے۔ اور نسل در نسل رہتی ہے۔ اسکی دو اقسام ہوتی ہیں Minor اور Major افراد میں اسکی علامات نظر نہیں آتی اور بے خبری میں اگر وہ Thalasemia والے افراد آپس میں شادی کرلیں تو نومولود کو اگر Thalasemia Major ہوجاتا ہے۔ اس لئے نہایت ضروری ہے۔ ایسے افراد آپس میں شادی نہ کریں۔ اسکا علاج نہایت تکلیف دہ اور مہنگا ہوتا ہے۔ جس میں باقاعدگی سے انتقال خون کی ضرورت پڑتی رہتی ہے۔ چند ادویات سے علاج ممکن ہے۔ خون کے بار بار استعمال سے side effect بھی ہیں۔ جس میں iron over load شامل ہے۔ مزید بھی آپ کو ساتھ ساتھ بتاتے رہیں گے۔

تعاون کا شکریہ۔

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Breaking Bad News (HIV)

السلام وعلیکم!

- میرا نام ڈاکٹر ندیم ہے۔ میں آپ کی بیماری کے متعلق آپ سے گفتگو کرنا چاہوں گا۔ اُمید ہے آپ تعاون کریں گے۔
- پیشہ ورانہ تقاضوں کو مدنظر رکھتے ہوئے ہماری ساری گفتگو صیغہ راز میں رکھی جائے گی۔
- آپ اپنی بیماری کے بارے میں کیا جانتے ہیں۔
- ڈاکٹر نے آپ کو آپ کی بیماری کے متعلق کیا بتایا ہے۔
- جیسا کہ آپ جانتے ہیں کہ کچھ عرصہ پہلے آپ نے کچھ ٹیسٹ کروائے تھے اُن کے نتائج موصول ہوئے ہیں اور مجھے نہایت افسوس کے ساتھ کہنا پڑ رہا ہے۔ کہ میرے پاس آپ کے لئے کوئی اچھی خبر نہیں ہے۔
- کیا آپ اس خبر کو سننے کے لئے کسی اور کو شامل کرنا چاہیں گے۔ (اگر ہاں) تو سب کچھ اس کو بھی بتائیں گے۔ جو ابھی تک مریض کو بتایا ہے۔
- مجھے نہایت افسوس کے ساتھ کہنا پڑ رہا ہے۔ کہ آپ کو ایڈز کا مرض لاحق ہے۔
- یہ ایک ایسا مرض ہے جس میں انسان کو قوت مدافعت بری طرح متاثر ہوتی ہے۔ جس کی وجہ سے اور بہت سی بیماریاں ہو سکتی ہیں۔
- میں سمجھ سکتا ہوں کہ اس وقت آپ پر کیا گزر رہی ہے۔
- یہ مرض ایک انسان سے دوسرے انسان میں خون اور جنسی تعلقات سے منتقل ہو سکتا ہے۔
- موزوں یہی ہے۔ کہ آپ اپنے شریک حیات کو بھی اس کے بارے میں بتائیں۔
- اس بیماری کا مکمل علاج تو ابھی تک سائنس نے نہیں تجویز کیا لیکن ایسی ادویات ضرور موجود ہیں جن کو وجہ سے قوت مدافعت بہتر ہو سکتی ہے۔ اور آپ کا معیار زندگی بہتر اپنایا جا سکتا ہے۔
- اللہ کی ذات سے ناامید نہ ہوں انشاء اللہ جلد آپ کی صحت میں بہتری آئے گی۔
- کیا آپ میری بات سمجھ رہے ہیں؟
- کیا آپ مجھ سے کچھ اور پوچھنا چاہیں گے۔

جلد ملاقات ہوگی۔

اللہ حافظ

Breaking Bad News (Cancer lung)

السلام وعلیکم!

- میرا نام ڈاکٹر نعیم ہے۔ میں آپ کی بیماری کے متعلق آپ سے گفتگو کرنا چاہوں گا۔ امید ہے آپ تعاون کریں گے۔
- پیشہ ورانہ تقاضوں کو مدنظر رکھتے ہوئے ہماری ساری گفتگو صیغہ راز میں رکھی جائے گی۔
- آپ اپنی بیماری کے بارے میں کیا جانتے ہیں؟
- ڈاکٹر نے آپ کو آپ کی بیماری کے متعلق کیا بتایا ہے؟
- جیسا کہ آپ جانتے ہیں کہ کچھ عرصہ پہلے آپ نے کچھ ٹیسٹ کروائے تھے ان کے نتائج موصول ہوئے ہیں اور مجھے نہایت افسوس کے ساتھ کہنا پڑ رہا ہے۔ کہ میرے پاس آپ کے لئے کوئی اچھی خبر نہیں ہے۔
- کیا آپ اس خبر کو سننے کے لئے کسی اور کو شامل کرنا چاہیں گے۔ (اگر ہاں) تو میں سب کچھ اس کو بھی بتاؤں گا۔ جو ابھی تک مریض کو بتایا ہے۔
- مجھے نہایت افسوس کے ساتھ کہنا پڑ رہا ہے۔ کہ آپ کو پھیپھڑوں کا سرطان ہے۔
- یہ سرطان آہستہ آہستہ آپ کے پورے جسم میں پھیل رہا ہے۔
- میں سمجھ سکتا ہوں کہ اس وقت آپ پر کیا گزر رہی ہے۔
- لیکن آپ ہمت رکھی اس مرض کا علاج ممکن ہے۔ ادویات اور شعاعوں سے بہت سے لوگوں کو آفاقہ ہے۔
- اللہ کی ذات سے ناامید نہ ہوں انشاء اللہ جلد آپ کو صحت میں بہتری آئے گی۔
- کیا آپ میری بات سمجھ رہے ہیں؟
- کیا آپ مجھ سے کچھ اور پوچھنا چاہیں گے۔

اللہ حافظ

Smoking

مجھے آپ کے مسئلے کے بارے میں بات چیت کرنے کو کہا گیا ہے۔آپ کچھ بتانا چاہیں گے۔

۱۔ آپ نے سگریٹ نوشی کب اور کیسے شروع کی؟

۲۔ دن میں کتنے سگریٹ پیتے ہیں؟

۳۔ کبھی ترک کرنے کے بارے میں سوچا؟

۴۔ کیا آپ ازدواجی یا معاشی مسائل سے دوچار ہیں؟

یہ جانتے ہوئے کہ سگریٹ صحت کے لئے کتنا مضر ہے۔ پھر بھی ہم اس جان لیوا عادت سے چھٹکارا حاصل نہیں کر سکتے۔اس سے زیادہ تر منہ اور سانس کی بیماریاں لگتی ہیں۔اس میں Nicotin اور CO ہوتی ہے۔جو ہمیں اسکا عادی بنا دیتی ہے۔ اس کو چھوڑنے کا سب سے آسان طریقہ یہ ہے۔مضبوط ارادہ کریں۔جب بھی سگریٹ کی طلب ہو تو تازہ ماحول میں لمبے لمبے سانس لیں۔پانی کا زیادہ استعمال کریں۔روزانہ ورزش کریں اور مصروف رہنے کی کوشش کریں۔

- گھر والوں اور دوستوں کو بتا دیں۔کہ آپ سگریٹ چھوڑ چکے ہیں تا کہ وہ حوصلہ افزائی کریں۔
- بعض ہسپتالوں میں سگریٹ نوشی کا علاج بذریعہ ادویات بھی کیا جاتا ہے۔جو بہتر ثابت ہوتا ہے۔اگر مشکل پیش آئے تو ماہر نفسیات سے رابطہ کریں۔

شکریہ۔

Breaking Bad News (Appendectomy)

السلام وعلیکم!

- میرا نام ڈاکٹر نعیم اختر جوئیہ ہے۔میں آپ کی بیماری کے متعلق آپ سے گفتگو کرنا چاہوں گا۔امید ہے آپ تعاون کریں گے۔
- پیشہ ورانہ تقاضوں کو مدنظر رکھتے ہوئے ہماری ساری گفتگو صیغہ راز میں رکھی جائے گی۔
- آپ اپنی بیماری کے بارے میں کیا جانتے ہیں؟
- ڈاکٹر نے آپ کو آپ کی بیماری کے متعلق کیا بتایا ہے؟
- جیسا کہ آپ جانتے ہیں کہ کچھ عرصہ پہلے آپ نے کچھ ٹیسٹ کروائے تھے ان کے نتائج موصول ہو چکے ہیں ان نتائج کو دیکھ کر میں اس نتیجے پر پہنچا ہوں کہ ہمیں آپکی بڑی آنت کا ایک حصہ جسے اپینڈیکس (Appendix) کہا جاتا ہے۔آپ کے جسم سے نکالنا ہوگا۔کیونکہ وہ آپ کے لئے خطرے کا باعث ہے۔
- یہ ایک معمولی سا آپریشن ہے جس کی شرح کامیابی بہت زیادہ ہے۔اس لئے پریشانی کی کوئی بات نہیں۔آپریشن کے دوران آپ کو خواب آور ادویات دے کر بے ہوش کیا جائے گا تا کہ آپ کو کم سے کم تکلیف ہو۔
- اس کے لئے مجھے قانونا آپ کی اجازت درکار ہے۔
- کیا آپ میری بات سمجھ رہے ہیں؟
- اس لئے میں آپ سے کچھ سوالات کرنا چاہوں گا۔آپ کا تعاون درکار ہے۔
  - میں کون ہوں؟
  - آپ کون ہیں؟
  - آج کیا دن ہے؟
  - آج کیا تاریخ ہے؟
  - یہ کون سا مہینہ ہے؟
  - آپ اس وقت کدھر بیٹھے ہوئے ہیں؟
  - یہ فارم لیں اور اس پر دستخط کر دیجئے۔
  - آیئے آپ کا آپریشن شروع کرتے ہیں۔

History Taking

السلام وعلیکم!

میرا نام ڈاکٹر محمد ندیم اختر جوئیہ ہے۔آپکا نام کیا ہے۔

۱۔ اصغر صاحب مجھے آپ کی بیماری کے بارے میں آپ سے بات چیت کرنے کو کہا گیا ہے۔
اجازت ہے؟

۲۔ اس وقت آپ کے ساتھ کون ہے۔اور آپ کہاں ہیں۔دوران گفتگو میں آپ سے ذاتی نوعیت کے سوال کروں گا۔اگر آپ
نے بتانا ہو تو بتا دیجئے گا۔

۳۔ کیا آپ اس وقت آرام سے بیٹھے یا لیٹے ہیں۔

(A) Introduction

Name	نام
Age/Sex	عمر
Married	کیا آپ شادی شدہ ہیں؟
Occupation	آپ کیا کام کرتے ہیں؟
Address	آپ کی رہائش کہاں ہے؟
(DOA)	آپ ہسپتال کس دن تشریف لائے؟
Mode of admission ER/OPD	آپ ایمرجنسی میں آئے تھے؟

Reflection

Mr. Asghar 25 years old male, married, labourer by occupation resident of Khan Garh has presented in hospital on 16 December through OPD with following chief complaints.

(B)

Chief complaints

Fever,

۱۔ آپ کس تکلیف کے ساتھ ہسپتال میں آئے۔

Don't Interrupt. Let the patient Speak

۲۔ میں نے آپ کی بات انتہائی صبر سے سن لی ہے۔آپ میرے ہر سوال کا جواب مختصراً ہاں یا نہ میں بتائیں۔

(C)

HOPI: (Most significant)

Detailed History:

On set, (sudden, insdious)	۱۔آپ کا بخار کیسے شروع ہوا؟
Duration	۲۔آپ کا بخار کب سے ہے؟
Progression (continuous/intermitent)	۳۔بخار ہونے کے بعد یہ مسلسل بڑھتا چڑھتا رہا؟
Aggravating / Relieving factors	۴۔کس چیز سے بخار کم زیادہ ہوتا ہے؟
Associated features (fever with rigor / chill)	۵۔بخار کے ساتھ کوئی مسئلہ جو اس کے تعلق رکھتا ہے۔
IF PAIN	۱۔نوعیت کیا ہے؟(دباؤ،جلن)
Character?	۲۔کیا مسئلہ ہے؟
Site	۳۔درد کہیں اور جاتا ہے؟
Rediation	
Associated Symptoms	
Reflection	

Suden my patient was in usual state of health 5 days ago when he developed fever, onset, continuous, high grade, relieved by taking panadol not associated with chill / Rigor. Patient will tell.

بخار کے علاوہ آپ کو کوئی مسئلہ ہے؟

جی مجھے بخار کے ساتھ کھانسی بلغم اور چھاتی میں درد ہے۔

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(D)

Other Possibilities

Meningitis

۱۔ کیا بخار کے ساتھ آپ کو سر میں درد اور گردن میں اکڑاؤ محسوس ہوتا ہے؟

Eye / Ear Infection

۲۔ .....کان، آنکھ سے پانی نکلتا ہے۔

۳۔ .....گلا خراب ہے؟

۴۔ .....پیٹ میں درد کے ساتھ پتلے پاخانے آتے ہیں؟

۵۔ .....پیشاب کرتے وقت درد / pus تو نہیں آ رہی ہے؟

۶۔ .....جلد پر چھالے یا السر تو نہیں؟

۷۔ .....جوڑوں میں درد، پیشاب میں جھاگ تو نہیں آ رہا؟

Lymphadenopathy

۸۔ .....گلٹیاں تو نہیں بن رہی؟

Weight loss?

۹۔ .....وزن کم تو نہیں ہو رہا؟

Reflection

Fever is associated with productive cough / dyspnea and chest pain.

Neck stiffness / headache eye / and Ear discharge ..... Sore throat ..... abdominal pain, diarrhea, Vomiting, Dysuria / pyuria

PV discharge ..... eruption ..... joint pain, skin rashes, frothy urine ..... weight loss lumps in the body.

(E)

Past History

۱۔ ماضی میں کبھی آپ کسی بیماری سے، آپریشن۔ بلڈ ٹرانسفیوژن۔ blood transfusion کے لئے داخل ہوئے؟

۲۔ ماضی میں کبھی آپ کو دمہ، ٹی بی، شوگر، فالج، دل کی تکلیف ہائی بلیڈ پریشر رہا ہے؟

(F)

Personal History

۱۔ اگر شادی شدہ ہیں تو کتنے بچے ہیں؟

۲۔ غیر شادی شدہ ہیں تو کتنے بہن بھائی ہیں؟

۳۔ کیا آپ سگریٹ نوشی کرتے ہیں اگر ہاں تو کتنے پیتے ہیں اور کتنے سالوں سے؟

۴۔ شراب نوشی کرتے ہیں۔ اگر ہاں

- کبھی کم کرنے کے بارے میں سوچا؟
- کیا آپ کے اپنی بیوی کے علاوہ دوسروں سے بھی تعلق ہے؟ (جنسی تعلق)

(Family History)

- کیا آپ کے خاندان میں بھی کسی اور کو ایسا مسئلہ ہے؟
- خاندان میں کسی کو ٹی بی، فالج، دمہ، بلڈ پریشر اور شوگر کا مسئلہ ہے؟

(Socioeconomic History)

- جس مکان میں رہتے ہیں کیا وہ آپ کا اپنا ہے؟
- کیا آپ کا گزارہ اچھے طریقے سے ہو جاتا ہے؟
- آپ کے ساتھ آپ کے گھر میں اور کون رہتا ہے؟

(Drug History)

- کیا آپ کوئی حکیم کی دوائی، جڑی بوٹیاں، جوڑوں کے درد کی دوائی، طاقت کی دوائی، ذہنی سکون کی دوائی استعمال کر رہے ہیں؟
- کیا آپ ٹی بی کی دوائی استعمال کر رہے ہیں۔ یا کسی اور بیماری کی دوائی استعمال کر رہے ہیں؟
- کیا بچوں کی پیدائش روکنے کے لئے کوئی دوائی استعمال کر رہی ہیں؟ (اگر خاتون ہے)

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(Gynaecology History)

- آپکی ماہواری کب شروع ہوئی۔
- .....کتنے دنوں بعد آتی ہے؟
- .....کم یا زیادہ تو نہیں آتی؟
- .....کے ساتھ پیٹ میں درد ہوتا ہے۔
- کیا آپ کا کبھی PAP SMEAR ہوا ہے؟

(IMMUNIZATION HISTORY)

- آپ نے کوئی حفاظتی ٹیکے لگوائے ہیں؟

(TRAVELLING HISTORY)

- کیا آپ کبھی ملک سے باہر گئے ہیں؟

(ALLERGIC HISTORY)

- کیا آپ کو کسی دوائی یا کسی انجکشن الرجی تو نہیں؟

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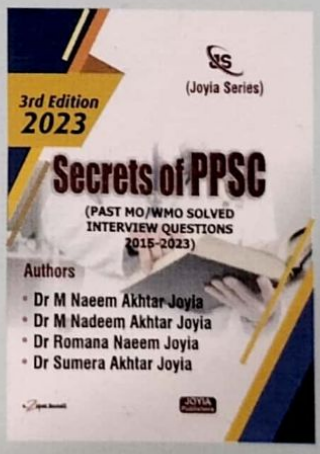

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